Making Health Care Decisions

The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship

Volume Three: Appendices Studies on the Foundations of Informed Consent

President's Commission for the Study of
Ethical Problems in Medicine and
Biomedical and Behavioral Research

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October 1982

President's Commission for the Study of
Ethical Problems in Medicine and
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President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research

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E

The Patient's Role in Medical Decisionmaking: A Social History of Informed Consent in Medical Therapy

Martin S. Pernick, Ph.D.*

Medical jurisprudence contains few concepts as controversial as "informed consent"—the doctrine that before a physician may administer any treatment the patient must be adequately informed about the proposed therapy and its effects and must freely consent to being treated. The phrase was first applied to the doctor-patient relationship in the 1957 case of Salgo v. Leland Stanford, Jr., University Board of Trustees. But this decision left unanswered many key questions: How much information must a patient have to make an adequately informed decision? Which patients lack the personal freedom, and which the mental competence, to make an informed choice? Who, if anyone, should have the power to decide for such patients? And what should be done when the shock of the information or the stress of the decisionmaking poses an actual risk to the patient's physical or mental health? Since 1957, judges, lawyers, physicians, and medical humanists have debated the definition, application, and purpose of informed consent, yet most of these basic issues remain unresolved.[1]

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November 1981

[1] Salgo v. Stanford University, 317 P. 2d 170 (Cal. 1st Dist. Ct. App., 1957). For an introduction to the basic issues see: Jay Katz, Experimentation with Human Beings (New York: Russell Sage Foundation, 1972); William A. Kelly, *The Physician, The Patient, and the Consent,* University of Kansas Law Review 8 (March, 1960), pp. 405-34; Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics (New York: Oxford University Press, 1979); Bernard Barber, Informed Consent in Medical Therapy and Research (New Brunswick: Rutgers University Press, 1980); Jay Katz, *Disclosure and Consent in Psychiatric Practice: Mission Impossible?* in Law and Ethics in the Practice of Psychiatry, ed. by Charles K. Hofling (New York: Brunner/Mazel, Inc., 1980) pp. 91-117; Bradford H. Gray, *Complexities of Informed Consent,* Annals of the American Academy of Political and Social Science 437 (May, 1978), pp. 37-48.

Although the current controversy is less than 25 years old, the question of what role a patient should play in deciding on a course of treatment is as old as the practice of medicine itself. Indeed, this medical issue derives from our ancient ambivalence about the appropriate role of experts in society. Philosophers since Plato have debated the choice between "paternalism" and "individual autonomy"; social scientists have traced the long history of conflict between "professionalization" and "egalitarianism."[2]

Despite the antiquity and significance of these underlying issues, the history of the patient's role in medical decisionmaking remains both controversial and obscure. Did an obligation to provide information and to seek consent exist in traditional medical ethics, or was "informed consent" imposed on doctors by the legal system? Was the goal of past policy to maximize the patient's chances of recovery, or was it to maximize the patient's personal autonomy, regardless of the effects on his health?

Answers to these and other historical questions are important, both because they deepen our understanding of the evolution of medical ethics, and because assumptions about the past have played a major role in shaping our current controversies. Many modern authorities endorse the view of Jay Katz that "disclosure and consent . . . have no historical roots in medical practice." Katz views informed consent as a concept alien to the professional values and therapeutic aims of medicine and warns contemporary policymakers that the legal concern for individual autonomy may conflict with ancient medical traditions. Others, however, claim a long history of physician concern for information-giving and consent-seeking. Mark Siegler finds elements of such decision-sharing accommodation among the free physicians of ancient Greece. This view of history may imply that informed consent need not pose a conflict between medical and legal values; between individual autonomy and human health.[3]

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[2] Even a partial bibliography is beyond the scope of this paper. An excellent survey is provided by the many articles on "professionalism" "paternalism," "informed consent," "therapeutic relationship," and similar entries in the ENCYCLOPEDIA OF BIOETHICS 4 vols. (New York: The Free Press, 1978).

[3] Katz, *Disclosure and Consent*, p. 98; Mark Siegler, *Searching for Moral Certainty in Medicine: A Proposal for a New Model of the Doctor-Patient Encounter*, BULLETIN OF THE NEW YORK ACADEMY OF MEDICINE 57 (January-February, 1981), p. 68. For other historical treatments see Stanley Joel Reiser, Arthur J. Dyck, and William J. Curran, eds., ETHICS IN MEDICINE: HISTORICAL PERSPECTIVES AND CONTEMPORARY CONCERNS (Cambridge: MIT Press, 1977); Laurence B. McCullough, *Historical Perspectives on the Ethical Dimensions of the Patient-Physician Relationship: The Medical Ethics of Dr. John Gregory*, ETHICS IN SCIENCE AND MEDICINE 5 (1978), pp. 47-53; Pedro Lain Entralgo, DOCTOR

In part, this debate derives from attempts to trace the history of "informed consent" as an isolated entity, abstracted from all social and historical context. But changes in medical technology, medical theory, professional power, and social structure all have interacted over time to shape the changing role of the patient in medical decisionmaking.[4] This essay will attempt to understand the evolution of informed consent within the context of larger medical, ethical, and social changes. In addition, this study will draw upon actual medical case records to recapture the important behavioral values that were transmitted through the example of daily medical practice, rather than studying exclusively the values prescribed by formal medical and legal codes.

Two conclusions will be suggested by this paper. First, truth-telling and consent-seeking have long been part of an indigenous medical tradition, based on medical theories that taught that knowledge and autonomy had demonstrably beneficial effects on most patients' health. Nineteenth-century American physicians generally did abide by this tradition; however, their views differed in both content and purpose from modern concepts of informed consent. And the belief that consent was therapeutically beneficial for most patients coexisted with the opinion that, for at least some patients, autonomous decisionmaking could be detrimental to their health.

The nineteenth-century American legal system carefully restricted itself to enforcing informed consent requirements only when medical experts testified that such consent comprised an ordinary and beneficial part of medical therapy. Not until the polarization of "science" and "values" at the turn of the century did American courts attempt to enforce informed consent as an independent legal and moral right, apart from judgments of what constituted appropriate medical practice.

Second, attempts to assess the decisionmaking "competence" of individual patients, not unlike attempts to measure "intelligence," have always included an element of value judgment. Thus, past standards of competence and consent have evolved in continuous response to changes in social and medical values, as well as to changes in medical technology. This observation need not dictate a totally relativistic approach to patient decisionmaking, but any attempt to utilize historical experience in shaping present policy should take into account the extent to which our concepts of consent have been contingent on ethical, technological, and social changes.

AND PATIENT (World University Library, New York: McGraw-Hill, 1969); Ronald L. Numbers, *William Beaumont and the Ethics of Human Experimentation*, JOURNAL OF THE HISTORY OF BIOLOGY 12 (Spring, 1979), pp. 113-35.

[4] McCullough, *Historical Perspectives*, pp. 47, 53.

Consent in Medical Theory, 1780-1880

To touch someone intentionally without their permission is to commit a battery.[5] Under this centuries-old legal definition, a doctor who treated a patient without the patient's consent could have been charged with battery (except in those emergencies in which the patient's wishes could not be ascertained).[6]

By contrast with this long-standing and explicit legal doctrine, the traditional codes of medical ethics mention little or nothing about patient consent, and express overt hostility towards providing the patient with much information on which to base a decision. The Hippocratic writings contain several well-known examples of treatments to which the physician should not consent (abortion, poisoning, lithotomy), but offer no definition of a doctor's duty towards a patient who refuses to consent to a prescribed therapy.[7] Medical injunctions against providing patients with accurate information are numerous, though such calls for deception usually involved hiding a hopeless prognosis rather than obtaining consent to therapy. The Hippocratic writings thus advocated "concealing most things from the patient . . . revealing nothing of the patient's future or present condition. For many patients through this cause have taken a turn for the worse. . . ."[8] One of the earliest commentators to specifically link information to the issue of consent was the blunt-spoken medieval French surgeon, Henri de Mondeville. He urged the surgeon to "compel the obedience of his patients" by selectively slanting the information provided. "He may exaggerate . . . if the patient has a bold and hardy spirit, or he may temper and soften the warnings, or keep silent altogether if the patient is faint hearted or good natured."[9]

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[5] American Law Digest Century Edition, *Assault and Battery*, sections 1, 3 (St. Paul: West Publishing Company, 1899).

[6] Jay Katz, *Informed Consent in the Therapeutic Relationship: Legal and Ethical Aspects*, Encyclopedia of Bioethics, II: p. 771.

[7] Katz, *Disclosure and Consent*, pp. 97-98.

[8] Hippocrates, *Decorum*, XVI, reprinted in Reiser, et al., Ethics in Medicine, p. 8. Note that such *medical* injunctions occasionally were made legally binding upon physicians, as in Visigothic Spain; see Loren C. MacKinney, *Medical Ethics and Etiquette in the Early Middle Ages: The Persistence of Hippocratic Ideals*, in Legacies in Ethics and Medicine, ed. by Chester Burns (New York: Science History Publications, 1977) pp. 176, 190, 198. See also Ludwig Edelstein, *The Hippocratic Oath*, and *The Professional Ethics of the Greek Physician*, in Legacies in Ethics and Medicine, pp. 12-101.

[9] Mary Catherine Welborn, *The Long Tradition: A Study in Fourteenth-Century Medical Deontology*, in Legacies in Ethics and Medicine, p. 213. For similar comments by a variety of legal and ethical commentators see note 23 below. "Truth-telling" and "consent" were traditionally treated separately, though as this quote shows, early writers did discuss various connections between the two. This paper will

Yet this hostility or indifference to informed consent does not mean that physicians always opposed patient decisionmaking. Mark Siegler quotes Plato's contrast between the Greek slave-physicians who gave orders "in the brusque fashion of a dictator," and the free physician, who "takes the patient and his family into confidence . . . [and] does not give prescriptions until he has won the patient's support. . . ."[10] Even Mondeville cautioned not to treat patients without obtaining their consent. Significantly, Mondeville based his injunction on purely medical reasoning. Citing Galen as his authority, Mondeville argued that "if the patient is defiant, seldom will the result be successful." Thus he concluded that if the surgeon could not obtain the patient's consent and confidence "he must not accept the case."[11]

By the late eighteenth century, in Europe and America, such physicians as John Gregory, Thomas Young, Benjamin Rush, and the French scientific-democrats Condorcet, Mirabeau, Cabanis, Volney, Chaussier, and Virey promulgated a vision of the doctor-patient contract in which the patient's informed deference to the physician's scientific knowledge would be reciprocated by the physician's respect for the informed patient's autonomy. They did not write specifically about "informed consent"; and their opinions on such issues appear inconsequential or illogical if they are isolated from their Enlightenment social and medical milieu. But these physicians did develop an influential indigenous medical tradition that encourages the doctor to share information and decisionmaking with his patients.

Physicians like Rush based their concern for consent on the holistic Enlightenment faith that everything in the social, moral, and natural environment affected human health. Thus, the education and the autonomy of patients constituted essential strands in the web of causation that determined both individual and public health. On this basis, Rush concluded that individual freedom directly promoted human health, and that even the most benevolently intentioned paternalism could cause disease. "There is an indissoluble union between moral, political and physical happiness." Rush even credited "the blessings of liberty" with "eradicating such loathsome and destructive disorders" as plague, leprosy, and elephantiasis from Revolutionary America.[12]

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focus on consent, studying truth-telling issues only as they affected or reflected patient decisionmaking.

[10] Siegler, *Moral Certainty*, p. 68, quoting Plato, The Laws, trans. by A.E. Taylor (London: Dent, 1934), pp. 104-105.

[11] Welborn, *The Long Tradition*, p. 213.

[12] George Rosen, *Political Order and Human Health in Jeffersonian Thought*, Bulletin of the History of Medicine, 26 (January-February, 1952), pp. 34, and 32-44 passim; Benjamin Rush, *Lectures on Animal*

Rush understood and accepted that such an intimate connection between health and freedom included the freedom of informed patients to judge and perhaps reject medical advice. At the height of the yellow fever epidemic that literally decimated Philadelphia in 1793, Rush introduced the heroic bloodletting and purging therapy that became his best-known legacy to medical history. When this lethal innovation aroused the bitter opposition of both patients and colleagues, Rush confidently submitted his proposals to the popular verdict. "The people rule here in medicine as well as government," he explained.[13]

Rush further realized that patient autonomy had to be based upon accurate information. Deceiving, or even withholding medical information, constituted for Rush the most serious vice of which physicians could be guilty.[14] He considered the dissemination of accurate scientific information the single most important means for physicians to combat disease; thus the education of both individual patients and the public at large constituted an essential part of every doctor's medical duties. Based on the Enlightenment assumption that "truth is simple upon all subjects," he urged physicians to "strip our profession of everything that looks like mystery and imposture, and clothe medical knowledge in a dress so simple and intelligible, that it may become . . . obvious to the meanest capacities."[15]

The views of Rush and his fellow medical democrats gave physicians strong medical reasons for sharing information and power with their patients. But these opinions constituted an endorsement neither of medical populism nor of modern "informed consent." They can only be understood as part of an Enlightenment world that tolerated disagreements as a means for discovering and promulgating an eventual universal consensus. Rush was reacting against previous physicians' demands

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Life, (1799) in THE SELECTED WRITINGS OF BENJAMIN RUSH, ed. by Dagobert D. Runes (New York: Philosophical Library, 1947), p. 135. For the similar views of Chaussier and Virey, see Erwin Ackerknecht, MEDICINE AT THE PARIS HOSPITAL 1794-1848 (Baltimore: Johns Hopkins Press, 1967), pp. 155-56; for Cabanis, see Martin Staum, CABANIS (Princeton: Princeton University Press, 1980) pp. 223, 234, 236; for Young see Pauline Maier, *Reason and Revolution: The Radicalism of Dr. Thomas Young*, AMERICAN QUARTERLY 28 (Summer, 1976), pp. 229-49; for Gregory, see Jeffrey Berlant, PROFESSION AND MONOPOLY (Berkeley: University of California Press, 1975) and McCullough, *Historical Perspectives*.

[13] Martin S. Pernick, *Politics, Parties, and Pestilence: Epidemic Yellow Fever in Philadelphia and the Rise of the First Party System*, WILLIAM AND MARY QUARTERLY 29 (October, 1972), p. 575.

[14] Rush, *The Vices and Virtues of Physicians*, (1801) in SELECTED WRITINGS, pp. 295-96, 305. "Candor in acknowledging mistakes," however, he ranked only among the "minor virtues."

[15] Rush, *The Progress of Medicine* (1801), in SELECTED WRITINGS, p. 236.

for blind and ignorant public deference to the authority of medical *rank*. He proposed to replace this medical dictation with a system in which properly educated patients would voluntarily defer to the authority of true medical *knowledge*. In this system, the laws of health, once rightly understood, could not help but harmonize with the laws of freedom. Any disagreement between doctor and patient over the proper therapy resulted from imperfect knowledge, not conflicting values. So long as patient ignorance still prevailed, Rush opposed allowing most patients to exercise very much therapeutic discretion. "It is a vice in a physician to study, more to please, than to cure his patients," Rush warned those doctors who feared patient opposition to his heroic cures. "The dependent state of physicians, upon public opinion . . . has checked innovation in the practice of medicine, and too often made physicians the apothecaries of their patients. . . . Do not condemn, or oppose, unnecessarily, the simple prescriptions of your patients," Rush chided the overly autocratic members of his profession. But he simultaneously cautioned doctors to "avoid sacrificing *too much* to the taste of your patients. . . . Yield to them in matters of little consequence, but maintain an inflexible authority over them in matters that are essential to life."[16]

Rush and other medical democrats based their concepts of consent upon the basic premise that informed individual liberty could promote individual health. While most eighteenth- and nineteenth-century doctors shared his holistic belief that autonomy directly *affected* health, the majority of practitioners appear to have regarded liberty as more likely to be pathogenic than therapeutic. For most physicians, paternalistic medical authority, rather than individual informed choice, constituted the healthiest social and medical order. Such views underlay the concept of "medical police" promoted by the early Prussian sanitarian J. P. Frank, which gained increasing support throughout the nineteenth century. The French physician Thouvenel wrote in 1806:

> It is important for the happiness of all that man be placed under the sacred power of the physician. That he be brought up, nourished, clothed after his counsel and that the systems according to which he should be governed, educated, punished, etc., be designed by him. . . . Who is better qualified to play this role than the physician who has made a profound study of his physical and moral nature?[17]

By the 1830s, even such American physicians as Amariah Brigham concluded that the mental stress of individual decisionmaking was more likely to cause than cure disease in at least some patients.[18]

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[16] Rush, *Vices and Virtues*," p. *298*; *The Progress of Medicine*, pp. 232-33; *Duties of a Physician* (1789), in SELECTED WRITINGS, p. 313.
[17] Ackerknecht, PARIS HOSPITAL, p. 154.

Historical explanations for this growing medical paternalism include the growing class and ethnic divisions in Western societies, the professional insecurities of nineteenth-century physicians, and the perceived failure of liberty to produce either consensus or health.[19] Medical paternalism most commonly expressed itself in the eighteenth- and nineteenth-century movements to build therapeutic hospitals and asylums. Such institution-building drew upon the medical doctrine that disease could be cured by constructing an environment in which every aspect of the patients' lives could be regulated to eliminate all pathogenic forces.[20]

The most influential medical code of the modern era was Thomas Percival's MEDICAL ETHICS. On the subject of consent, Percival offered the paternalistic-sounding advice that physicians should unite "condescension with authority."[21] Yet in context Percival's position was a moderate attempt to reconcile the extremes represented by Rush and Thouvenel. Percival's injunction concludes a brief section on doctor-patient disagreements. Taken as a whole, the point of the passage is that patients whose individual choices were "silenced by authority" would be made sicker by such dictation. Percival's choice of the word "condescension" to describe the physician's acceptance of patients' wishes was not intended to be patronizing towards *all* patients. Instead, the word reflected the origins of his code as a manual for use among the pauperized patients of urban charity institutions. The "condescension" resulted from the overriding of class considerations by medical necessity, not from the overriding of medical authority *per se*.[22]

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[18] Brigham, REMARKS ON THE INFLUENCE OF MENTAL CULTIVATION AND MENTAL EXCITEMENT UPON HEALTH, 2nd ed. (Boston: Marsh, Capen & Lyon, 1833). For similar examples see George Rosen, *Social Stress and Mental Disease in the Eighteenth to Twentieth Centuries*, MILBANK MEMORIAL FUND QUARTERLY 37 (January, 1959), pp. 5-32; David Rothman, THE DISCOVERY OF THE ASYLUM (Boston: Little, Brown and Company, 1971), pp. 109-54, esp. 118-19.

[19] For widely differing interpretations of this trend, see Rothman, DISCOVERY OF THE ASYLUM; Gerald Grob, MENTAL INSTITUTIONS IN AMERICA (New York: The Free Press, 1973); Barbara Sicherman, *The Paradox of Prudence: Mental Health in the Gilded Age*, JOURNAL OF AMERICAN HISTORY 62 (March, 1976), pp. 890-912; and Michel Foucalt, THE BIRTH OF THE CLINIC: AN ARCHAEOLOGY OF MEDICAL PERCEPTION (New York: Pantheon Books, 1973).

[20] The best explanation of this strain of thought is Charles Rosenberg, *Florence Nightingale on Contagion: The Hospital as Moral Universe*, in HEALING AND HISTORY (New York: Science History Publications, 1979), pp. 116-36. See also his *And Heal the Sick: The Hospital and the Patient in 19th Century America*, JOURNAL OF SOCIAL HISTORY 20 (June, 1977), pp. 428-47.

[21] Thomas Percival, PERCIVAL'S MEDICAL ETHICS (1803), ed. by Chauncey D. Leake (Baltimore: Williams & Wilkins, 1927), pp. 71-72.

Similarly, Percival provided a middle-of-the-road approach to the role of information in a patient's consent to treatment. He underlined his intended moderation by presenting his views after a wide-ranging survey of more extreme nonmedical authorities, from St. Paul to Samuel von Puffendorff. Most of these lay authorities agreed with the Scottish philosopher Francis Hutcheson, that deceptively obtained consent could be justified by its therapeutic benefits: "No man censures a physician for deceiving a patient too much dejected, by expressing good hopes of him, or by denying that he gives him a proper medicine which he is foolishly prejudiced against." "Those are by no means guilty of lying, who . . . invent something that is false . . . for persuading a nauseating patient to take his physic . . . ,"Percival quotes Puffendorff. At the other extreme, Samuel Johnson was quoted as opposing all medical deception, both on the grounds that "you have no business with consequences; you are to tell the truth," and on the more utilitarian logic that truth-telling was often unexpectedly therapeutic.[23]

Following this extensive survey of lay opinions on medical truth-telling Percival offered his own medical conclusion: that the golden rule commanded full disclosure and honesty in all doctor-patient communications, except in those very rare "real emergency" situations in which the patient's higher right "to be guarded against whatever would be detrimental to him" could override his right to truth.

In America, Worthington Hooker's seminal PHYSICIAN AND PATIENT of 1849 generally followed Percival's lead on ethical issues. However, on the issue of truth-telling Hooker took the more radical position that deception always did more medical harm than good. Even when the patients were children and/or insane, Hooker denounced all deception as harmful to the patient's health. But where Benjamin Rush saw a direct connection between medical truth-telling and patient decisionmaking, Hooker saw the obligation to inform as separate from and superior to the issue of autonomy. Indeed Hooker's support for absolute truth-telling was contingent upon absolute medical authority over the incompetent patient; in the "care of the insane . . . force is always preferable to deception."[24]

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[22] Percival, MEDICAL ETHICS, p. 84, makes the class considerations clear.

[23] This and the following paragraph are based upon the 1849 Oxford edition of MEDICAL ETHICS, pp. 132-41, corresponding roughly to pp. 191-96 in the Leake edition. Thomas Percival, MEDICAL ETHICS 3rd ed (Oxford: John Henry Parker, 1849) available also in Reiser, et al., ETHICS IN MEDICINE, pp. 203-205.

Not only were non-medical commentators usually hostile to medical truth-telling; the few surviving early remarks on medical consent were also hostile to patient autonomy. See the fifteenth century views of Saint Antoninus of Florence: " . . . even if the sick man forbids any medicines to be given to him, a physician called by him or by his relatives, can treat the patient against the patient's will, just as a man ought to be dragged against his will from a house that is about to collapse." Quoted by Darrel Amundsen, *The Physician's Obligation to Prolong Life: A Medical Duty without Classical Roots*, HASTINGS CENTER REPORT 8 (August, 1978), p. 28.

In summary, while eighteenth- and nineteenth-century medical codes did not specifically discuss "informed consent," the medical theories of the era clearly shaped the ways in which physicians responded to doctor-patient conflicts. The holism of medical science focused physicians' attention on the important role that the doctor-patient relationship could play in directly influencing health and disease. Thus providing information and sharing decisionmaking were evaluated, not as ends in themselves, but as means to both individual health and scientific truth.[25]

Based upon such reasoning, Benjamin Rush and other physician democrats developed an indigenous medical tradition of support for an Enlightenment version of informed consent. But their faith that "liberty fertilizes life,"[26] was increasingly circumscribed by later nineteenth-century physicians who viewed autonomy as a danger to the health of most patients. These positions were not exclusive opposites, but rather were the endpoints of a continuum. Few physicians denied that informed patients' decisions could sometimes help and sometimes hurt. The relative balance of risks and benefits, of the numbers helped and the numbers harmed, seems to have shifted in a more paternalistic direction over the course of the century.

Consent in Practice

Mid-Nineteenth-Century Surgery. While the medical literature thus reveals an unexpected level of physician concern with issues of patient decisionmaking, a full understanding of such concepts requires attention to their actual application in practice. Routine medical and surgical case records shed some light on what types of therapeutic decisionmaking were accepted as noncontroversial by the medical community; legal case records reveal the areas of authority that led to disputes, and the means by which the legal system resolved such differences.

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[24] Worthington Hooker, PHYSICIAN AND PATIENT (New York: Baker and Scribner, 1849), Chap. XVII, esp. p. 369. While Hooker held physicians to a rigorous standard of truth-telling he also had a rigorous definition of "truth," one shared by most nineteenth-century clinicians. For Hooker, only certainties, not probabilities, counted as facts. Hooker was more familiar with and favorably disposed towards the infant science of medical statistics than were most of his contemporaries. Yet even he conflated exactly known probability odds with "a mere guess." He thus concluded that only certainties need be shared with the patient. See PHYSICIAN AND PATIENT, pp. 381-82.

Most other nineteenth-century physicians shared this reluctance to consider probability data as facts; see AMERICAN JOURNAL OF THE MEDICAL SCIENCES 23 (1852), p. 131.

[25] McCullough, *Historical Perspectives*, p. 51.

[26] The quote is from Virey, in Ackerknecht, PARIS HOSPITAL, p. 156.

Even a cursory glance at nineteenth-century American medical records is sufficient to document the enormous problem posed by patients' reluctance to undergo surgery. In an era when hospital operations were often seen as synonymous with pain, mutilation, infection, and death, hospital patients in particular viewed surgery as the last resort. Cultural conflicts between immigrant patients and native physicians further exacerbated such disagreements.[27]

Yet in the majority of such cases, the patient's desires were heeded, even when the result was the patient's death. In part, the willingness of surgeons to refrain from operating simply reflected surgical acceptance of the gloomy prognosis regardless of treatment. The largest mid-nineteenth-century American hospitals rarely exceeded one major operation a day; sometimes there would be no surgery done for a week or more. The death rate for major limb amputations ranged from 25 to 35% or more.

But even when the surgeons judged an operation essential to save a life, a patient's objections could usually prevent the procedure. The comments in such case records reveal the mixture of frustration and resignation with which nineteenth-century surgeons regarded patient decisionmaking. For example, a six-year-old boy arrived at New York Hospital in 1855, shortly after a train had crushed his arm. "Patient's friends strongly refuse to give their consent, and would rather the child should die than loose [sic] its arm," the doctor angrily recorded. Still, the operation was not performed.[28] A tantalizingly brief note of 1860 records a similar case in which the consent issue apparently provoked a bitter debate over medical ethics between the house officer and the attending surgeon. A premature explosion had burned and mangled the face and hands of an Irish rockdriller. When the injured man was brought to New York Hospital, the eminent attending surgeon Dr. Gurdon Buck ordered the immediate amputation of three of the laborer's fingers. But the house surgeon, a post roughly equivalent to a modern surgical intern, acceded to the requests of the patient and his family that no operation be performed. "[T]he pt's spouse being exceedingly anxious that he sh'd be taken home to the domestic fireside, . . . the accomplished benevolent H.S. discharged the pt . . . ," Dr. Buck fumed sarcastically.[29]

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[27] The cases described in the following three paragraphs, as well as those in the section on anesthesia, are based in part upon the following surgical case records: Massachusetts General Hospital, Surgical Records, volumes 22-24 (1840-41), 29-33 (1845-47), 62-67 (1854-55), 84-89, 91 (1859-60), and 127-134 (1866-67), manuscript case books located at the Countway Library of Medicine, Boston. New York Hospital, Surgical Records, 1845-46, 1st and 2nd divisions; 1847-48, 1st division; 1854-55, 1st division; and 1859-60, 1st and 2nd divisions, manuscript case books located at the New York Hospital Archive, New York. Pennsylvania Hospital, Fracture Books, 1852-1869. Manuscript case books located at the Pennsylvania Hospital Archive, Philadelphia.

[28] New York Hospital, Surgical Records, 1st surgical division (1855) volume 18, number 222.

Such case records are remarkable not only for their explicit recording of medical emotions, but even more for their lack of any explicit reference to legal considerations. On the other hand, nineteenth-century legal records reveal that, in cases involving surgical consent, American courts almost always deferred to medical judgment. The legal system disciplined surgeons who violated the wishes of their patients only when the evidence indicated that the lack of consent violated medical norms.

In the nineteenth century, as today, a surgeon who operated without the patient's permission could be subject to two different legal actions, either battery or malpractice. In an action for battery, the patient had only to show that no valid consent had been given for the operation. Malpractice required proof that consent was so integral to ordinary medical care that its absence constituted negligence. Battery theory regarded the patient's autonomy and bodily integrity as independent rights, regardless of their effect on the medical outcome. Negligence law established the patient's right to only as much freedom as was medically indicated.[30]

Most legal scholars have long assumed that surgical consent cases were traditionally treated as batteries.[31] In fact, the handful of such cases discovered from the period before 1890 were almost all tried as malpractice. Of course, various other technical considerations may have influenced the choice of action. But the use of negligence rather than battery clearly indicates that nineteenth-century American law viewed patient decisionmaking as a means toward the goal of therapy, rather than as an independent individual legal right.

Nineteenth-century malpractice law could be used to justify fairly sweeping and stringent informed consent requirements, provided that information and decision sharing could be shown to be ordinary parts of good medical care. The fascinating and complex 1871 New York case of Carpenter v. Blake illustrates how far-reaching such malpractice cases could be. Dr. Baker had treated Mrs. Carpenter's injured arm. After some time, he assured her that the arm was mending and he stopped his therapy. When she discovered the arm had not healed she sued for malpractice, charging, in part, that her consent to the termination of treatment had been based on false and misleading information. Mrs. Carpenter's counsel stated the informed consent issue as follows: "If the plaintiff's assent . . . was of any use or protection to him, it must have been an assent voluntarily given, with a full knowledge of all the facts, and not one procured by fraudulent representations. It is more than evident that the chief mischief done to the arm was . . . rendered permanent by . . . his frequent assurances that it was all right."[32]

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[29] New York Hospital, Surgical Records, 1st surgical division (1859-60), volume U, number 205. For more examples see note 75 below.

[30] See Kelly, KANSAS LAW REVIEW, pp. 410-11, 423; Katz, *Informed Consent*, p. 771.

[31] Katz, *Informed Consent*, p. 771: "Consent to medical and surgical interventions is an ancient legal requirement. Historically an intentional touching without consent was adjudicated in battery. The law has not changed at all in this regard. . . . ."

The court agreed that "the consent of the plaintiff, if obtained by false representations," was invalid. But the ruling went much further, holding that in this case a separate medical duty to tell the truth existed, even apart from the issue of obtaining valid consent. Whenever it would benefit a patient's health to know his true condition, the court implied, it would be malpractice for a doctor to withhold that information. Whenever a patient's condition posed avoidable dangers,

> the danger should be disclosed, to the end that all proper precautions may be taken to prevent it. It is insisted that these dangers were imminent, and yet no word was given. This was, in my judgment, culpable negligence; much of the suffering the plaintiff has undergone, and much of the loss she has sustained, might have been prevented, had the defendant done what it was clearly his duty to do. . . ."[33]

The case wound its way up and down and up again through the New York courts. But in the end New York's highest tribunal upheld and extended both the truth-telling and the informed consent principles of the 1871 ruling. In their 1878 decision, a unanimous Court of Appeals stated that the doctor's failure to inform Mrs. Carpenter of her true condition invalidated her consent to the cessation of treatment. "[I]f the defendant was dismissed with the plaintiff's assent, she had no right to hold him responsible for any subsequent results of the arm," but if "he deceived and misled her . . . he should be held responsible for the injury that occurred after that time." In addition, the high court upheld the 1871 ruling that the doctor had an obligation to give the patient any information routinely required to promote successful therapy, separate from his duty to obtain her informed consent:

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[32] 60 Barb. 488 (N.Y. Sup. Ct., 1871), at 507.

[33] 60 Barb. 488, at 520, 515.

> If what was said in regard to the condition of the arm, misled the plaintiff in respect to the importance of giving it additional attention . . . no reason is apparent why he should not be held responsible for the consequences which followed. . . . Proper instructions may have avoided much of the suffering to which the plaintiff was subjected, and prevented the serious consequences which followed.[34]

In other cases, surgeons who performed operations without obtaining an informed consent were held to have committed malpractice.[35]

Nineteenth-century malpractice cases thus upheld the patient's right to information and choice, but only in so far as informed consent constituted good medical practice and helpful therapy. However, most nineteenth-century physicians believed information and decisionmaking could be harmful to the health of some patients, and the courts almost always agreed.

In the 1853 case of Twombly v. Leach, a Massachusetts woman charged that "the defendant fraudulently represented to the female plaintiff that her hand was getting well, and in consequence of it she failed to apply to other physicians, so that she lost the use of her hand." She also alleged that the surgeon obtained permission to operate on her hand by withholding information and by lying about the nature of the surgery.[36]

The court agreed that "there was evidence tending to show that the defendant did not communicate to the plaintiff what the disease was; that he opened the thumb . . ." under false pretenses. But the justices held that if such behavior could be justified on medical grounds it might well be permissible. "Upon the question whether it be good medical practice to withhold from a patient in a particular emergency, or under given or supposed circumstances, a knowledge of the extent and danger of his disease, the testimony of educated and experienced medical practitioners is material and peculiarly appropriate."[37] The summary report of this case in the AMERICAN DIGEST stated the conclusion even more sweepingly: "In an action for malpractice in treating a cut on plaintiff's thumb, defendant should have been allowed to show that it is good medical treatment in some cases to withhold from a patient the extent of the disease and her actual condition. . . ."[38] An 1869 Oregon case echoed the same principle. "If a surgeon purposely refracture a broken arm, without informing his patient of the nature of the operation, it does not follow, from that fact alone, that he was guilty of bad surgery. . . ."[39]

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[34] 75 N.Y. 12, at 23, 21, 19. For the full history see: 50 N.Y. 696; 2 Lan. 206; 10 Hun 358. For medical reaction see T.C. Becker, *Carpenter vs. Blake: An Important Decision by the Highest Court of New York State for an Action for Malpractice*, PHYSICIANS AND SURGEONS' INVESTIGATOR (Buffalo, NY), I (1880), pp. 119, 144. Katz, EXPERIMENTATION, p. 527 quotes part of the 1871 decision but overlooks the informed consent aspects. While Katz correctly notes the 1872 remanding, he fails to trace the subsequent retrial and 1878 reaffirmation of the 1871 principles and verdict.

[35] Wells v. World's Dispensary Medical Association, 120 N.Y. 630, 24 N.E. 276 (C. App. N.Y. 2nd div., 1890). In this case, the appellate court appeared to be straining to uphold the decision of a jury which had reached a just verdict based on a misunderstanding of the law.

[36] 65 Mass 397, at 398.

A nonreported New York City trial of 1880 reveals just how lenient nineteenth-century courts could be in accepting medical justifications for violating a patient's wishes. Dr. Henry D. Noyes operated upon, and blinded, both eyes of a cataract patient, who had repeatedly insisted that only one eye should be treated. Even in this extreme situation, the doctor was charged with malpractice, not with battery. Four medical witnesses were allowed to testify that "such action was entirely within the scope of discretion ordinarily assumed by surgeons," and the jury voted ten to two for acquittal.[40]

Thus, nineteenth-century American courts judged surgical informed consent cases according to the malpractice standard of ordinary medical duty. A thorough search of the basic medical and legal sources failed to find even one case report of an American physician charged with battery in therapy prior to 1889, although a handful were reported from England.[41] One well-known early British case, Slater v. Baker (1767), involved a surgeon who refractured a man's broken leg without the patient's permission. But, while the judge held that such conduct could constitute battery, the decision itself rested solely on the novel, reckless, and negligent manner in which the procedure was performed. No battery was alleged and no damages for battery were awarded.[42] The only successful battery prosecution reported was The Queen v. William Case, a British criminal trial of 1850. Case was found guilty of battery for convincing a 14-year-old girl to have sex with him by telling her it was a form of medical treatment.[43]

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[37] 65 Mass 397, at 401, 405.

[38] AMERICAN DIGEST, CENTURY EDITION, *Physicians and Surgeons*, Volume 39, p. 975.

[39] *Boydston v. Giltner*, 3 Oregon 118.

[40] *The Patient's Consent to an Operation and the Surgeon's Discretion*, THE MEDICAL RECORD (New York), 18 (1880), p. 715. Interestingly, both the judge and the physician-reporter believed the case to have been unprecedented.

[41] In addition to the sources cited throughout this paper, the following indexes were examined: AMERICAN DIGEST, CENTURY EDITION: *Assault and Battery, Physicians and Surgeons, Fraud, Contracts*. INDEX-CATALOGUE OF THE SURGEON GENERAL'S LIBRARY, 1st ser.: *Malpractice, Physicians, duties of, Medical Jurisprudence, Medical Ethics*.

[42] 95 English Reporter 860, excerpted in Katz, EXPERIMENTATION, pp. 526-27; 2 Wilson 259; John J. Elwell, M.D., A MEDICO-LEGAL TREATISE ON MALPRACTICE AND MEDICAL EVIDENCE 3d ed. rev. and enl. (New York: Baker, Voorhis & Co., 1871), pp. 112-15.

Undoubtedly there were some American physicians convicted of medical battery. These cases most likely involved situations in which no therapeutic intent could plausibly be claimed by the physician. Such cases would not have been likely to be reported, and many were undoubtedly settled out of court.

However, newspaper accounts occasionally offer a fascinating glimpse of such nonreported medical battery cases. One particularly colorful example, from the BROOKLYN DAILY EAGLE of 1846, concerned a violation of consent allegedly perpetrated during a public exhibition of mesmerism. Itinerant lecturers, who demonstrated mesmerism, laughing gas, and ether, were commonplace popular entertainment in the 1840s. Such lectures provided the setting for some of the earliest medical observations on inhalation anesthesia. Mesmerism too had recently gained medical attention as a possible surgical anesthetic.[44] This particular mesmeric exhibition, held exactly two months after the first public demonstration of surgical anesthesia, apparently stimulated the experimental spirit in one medical member of the audience. The lecturer had mesmerized an obese female volunteer, and, according to the newspaper account, "pronounced her insensible to feeling. A doctor among the audience being curious to know the state of her nerves, sprinkled a little cayenne pepper upon her nostrils and lips. . . ," throwing her into a violent convulsion fit. "She is going to bring a suit for damages against the doctor," reported the *Eagle*, "for assault and battery with cayenne pepper."[45]

Mid-Nineteenth-Century Medicine. While nineteenth-century doctors and judges thus concurred that surgeons should be held to a medically based standard of informed consent, the situation in internal medicine was more complex. Unlike surgery, the prescription of drugs did not require touching the patient, so battery allegations were even less of a potential threat to physicians than to surgeons. Furthermore, taking a drug was usually a voluntary act of the patient. And prior to the twentieth century, patients had few legal rights to know what was in the medicines they took, except in so far as the sale of grossly mislabelled items might constitute fraud or negligence.[46]

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[43] 5 British Crown Cases 587; Elwell, MEDICO-LEGAL TREATISE, pp. 240-42. For a British case in which a battery prosecution charge was handled as a malpractice case, see Absolon v. Stratham, note 71 below.

[44] George Rosen, *Mesmerism and Surgery: A Strange Chapter in the History of Anesthesia*, JOURNAL OF THE HISTORY OF MEDICINE AND ALLIED SCIENCES 1 (October, 1946), pp. 527-50; Frank K. Boland. THE FIRST ANESTHETIC: THE STORY OF CRAWFORD LONG (Athens: University of Georgia Press, 1950), p. 46; W. Harry Archer, *Life and Letters of Horace Wells, Discoverer of Anesthesia*, JOURNAL OF THE AMERICAN COLLEGE OF DENTISTRY, 11-12 (1944-45), pp. 81-210.

[45] BROOKLYN DAILY EAGLE, December 17, 1846. The author of the article may well have been the editor, the young Walt Whitman.

The lack of consensus on medical consent was exacerbated by the many internal conflicts within nineteenth-century American medicine. The profession was bitterly divided among competing sects of homeopaths, hydropaths, eclectics, botanics, and others, in addition to the "regular" or "allopathic" practitioners; within each sect "heroic" and "nihilistic" proclivities produced further divisions.

These rivalries shaped nineteenth-century approaches to medical consent in several important ways. First, the doctors' disagreements over what constituted medical knowledge made it difficult to adopt any legal information-providing requirements, since enforcement of such rules might require adopting one sect's definition of what constituted "information." Second, the variety of competing sects and the unrestricted number of practitioners gave the nineteenth-century patient a great deal of de *facto* autonomy without formal regulations. Neither the law nor medical ethics consistently required anything like informed consent in drug therapy, but the wide-open medical marketplace guaranteed that most paying patients who wanted either information or a particular kind of therapy could shop around for it.[47] Third, the multiplicity of medical theories made doctor-patient conflicts over therapy an everyday aspect of medical practice. Fourth, free market forces created tremendous pressure on those physicians who believed in the medical value of unpopular medicines to use deceit or force, to protect both the doctor's livelihood and the patient's life.

Published case records show that many practitioners were accused of deliberately deceiving patients into taking unwanted medications. The most common complaints concerned physicians who added mercury to prescriptions against the expressed wishes of their clients. The use of such mercurial compounds as calomel was central to orthodox medical therapy, but increased awareness of the dangerous long-term side effects led to growing patient hostility towards the drug. By the 1840s charges that doctors were resorting to blatant deception in the use of mercury appeared regularly in both the popular and professional press.[48]

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[46] Some states did pass drug labelling laws in the nineteenth century, prodded by physician-politicians like T. O. Edwards of Ohio. For the ease with which such laws were circumvented, see the BROOKLYN DAILY EAGLE, April 13, 1847, for an account of a Maine patent drug manufacturer who allegedly listed his product's ingredients in Chinese. On drug labelling in general see Peter Temin, TAKING YOUR MEDICINE: DRUG REGULATION IN THE UNITED STATES (Cambridge: Harvard University Press, 1980) pp. 18-27; James Harvey Young, THE TOADSTOOL MILLIONAIRES: A SOCIAL HISTORY OF PATENT MEDICINES IN AMERICA BEFORE FEDERAL REGULATION (Princeton: Princeton University Press, 1961).

[47] Elwell, MEDICO-LEGAL TREATISE, p. 29.

However, such charges do not prove that doctors condoned such disregard for patient autonomy. Most often, such stories were reported by physicians whose primary concern was to fight against mercurial drugs, not to argue ethics. Most simply assumed that deceptive drugging was unethical and used this type of case as a reflection upon the characters of orthodox heroic practitioners. Those medical writers who commented on the ethical issues unequivocally rejected such deception, on both utilitarian and deontological grounds.[49]

Victims of such abuses had grounds for legal action, for fraud and perhaps for malpractice. In nonmedical cases, the common law recognized clandestine administration of drugs as a criminal assault;[50] yet only one nineteenth-century case report even mentioned the issue, and then only in passing.[51]

Specific Case Studies

While the examples discussed so far provide an overview of consent issues in nineteenth-century general practice, the complex influence of social and technical changes on attitudes towards patient autonomy can best be studied through a more detailed examination of specific problem areas. Two unusual types of medical cases prove especially revealing. First, the practice of medicine under the system of slavery in the antebellum South starkly dramatized the conflicts among social, legal, and medical views of patient autonomy. Second, the 1846 introduction of anesthetics illustrated the ways in which new technology may affect the medical view of consent.

Slavery. In antebellum law, a master's approval was the only consent considered valid or necessary for a physician to treat a slave. The slave had no legal say in deciding upon his therapy; he could neither resist a therapy approved by his owner nor seek out treatment to which the master was opposed.

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[48] For one example, in which a newspaper reprinted such a story from a medical journal, see BROOKLYN DAILY EAGLE, February 3, 1847. For others, see Charles Rosenberg, THE CHOLERA YEARS (Chicago: University of Chicago Press, 1962), p. 157; William G. Rothstein, AMERICAN PHYSICIANS IN THE NINETEENTH CENTURY (Baltimore: Johns Hopkins University Press, 1972), p. 128.

[49] Hooker, PHYSICIAN AND PATIENT, pp. 362, 366.

[50] Commonwealth v. Stratton, 114 Mass 303, 19 Am. Rep. 350 (1873).

[51] Elwell, MEDICO-LEGAL TREATISE, p. 149, a British case, tried as malpractice and decided on other grounds.

In general, this situation usually did not produce disagreement. The owner's economic and paternalistic concerns usually coincided more or less with the slave's interests in preserving life and limb.[52] But there were troubling exceptions. Many slaves rejected the basic assumptions of white medical practice and, whenever possible, insisted upon Afro-American folk remedies instead.[53] In selecting remedies, the owner was liable to favor the cheapest while the slave would favor the least painful.

Most importantly, the owner's interests coincided with the slave's only when full recovery seemed likely. In cases of chronic disability, the owner would benefit from any procedure that promised a radical cure, regardless of novelty, pain, likelihood of success, or degree of danger. Conversely, if a life-saving therapy required creating a permanent disability—for example, the amputation of a gangrenous leg—the planter's economic interests clearly favored withholding consent. Though the paternalistic sentiments of the master and the laws against murder provided some protection, the safeguards were clearly inadequate. Economically, a dead slave was far preferable to a crippled one.

The noted pro-slavery spokesman Dr. Josiah C. Nott explained the situation succinctly in cautioning prospective investors about a plan to sell life insurance for slaves:

> As long as the negro is sound . . . self-interest will prompt the owner to preserve the life of the slave; but, if the slave become unsound, and there is little prospect of perfect recovery . . . it ceases to be the interest of the owner to preserve the life of the slave [and] he will in many instances cease to be careful of it.[54]

Under such a system, physicians were sometimes legally required to treat patients in ways that deeply violated nineteenth-century medical values. Some Southern physicians clearly took advantage of the situation and conducted exceedingly brutal and cruel experiments that could never have been conducted upon autonomous patients. Dr. Thomas Hamilton of Georgia placed a slave in a pit oven in an attempt to study the causes and cure of heat stroke.[55] Dr. Walter Jones of Virginia and several other Southern doctors poured scalding water over naked sick slaves in an experimental cure for typhoid fever.[56] One Thomsonian physician advertised in 1844, "diseased servants purchased, and a liberal price given for such as are considered incurable."[57]

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[52] Todd L. Savitt, MEDICINE AND SLAVERY: THE DISEASE AND HEALTH CARE OF BLACKS IN ANTEBELLUM VIRGINIA (Urbana: University of Illinois Press, 1978), pp. 242, 272.

[53] Eugene Genovese, ROLL, JORDAN, ROLL: THE WORLD THE SLAVES MADE (New York: Pantheon Books, 1974) pp. 224-32.

[54] J. D. B. De Bow, INDUSTRIAL RESOURCES, 2 vols. (New York: D. Appleton & Co., 1854), II, pp. 298-99; quoted in Leslie Howard Owens, THIS SPECIES OF PROPERTY (New York: Oxford University Press, 1976), p. 26.

[55] Savitt, MEDICINE AND SLAVERY, p. 293.

Most such experiments in internal medicine bore no fruit, but in surgery, experiments on slaves led to several major advances in therapy. J. Marion Sims of Alabama developed the first effective operation for vesico-vaginal fistula in a four-year series of multiple operations on a half-dozen slave women. Ephraim McDowell performed four of his first five experiments in ovariotomy upon slaves.[58] Less well-known is Georgia's Dr. Crawford Long, who in 1842 conducted the first controlled trial of anesthesia by amputating two fingers from a slave boy—one with ether, the other without.[59]

Yet despite such examples, at least a few eminent Southern doctors defended a medical tradition that insisted upon the right of any patient to seek or refuse treatment—even when such medical respect for patient autonomy had no legal sanction. Dr. Paul Eve of Georgia, a founder and later president of the American Medical Association and perhaps the most eminent Southern surgeon of the mid-nineteenth century, ignored the law and operated on slaves only when the patients themselves consented. For example, in reporting an early hysterectomy performed on a slave woman, Eve emphasized that the decision to operate "rested entirely with herself."[60] Sims defended his fistula experiments by claiming the slaves had always consented to his attempts to cure their painful, loathsome disease. In at least one case, Sims apparently bought a fistulous servant after her master had refused to grant her requests for treatment.[61]

In 1856, a Virginia slave charged that physicians at a medical college had amputated his ulcerous leg "just to let the students see the operation." The VIRGINIA MEDICAL JOURNAL investigated and urged that the surgeon "be mulcted with heavy damages for malpractice."[62] But, despite the outrage of the medical press, the master apparently did not complain; thus no legal remedy existed.

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[56] Savitt, MEDICINE AND SLAVERY, p. 299; Rosenberg, CHOLERA YEARS, p. 60.

[57] Young, TOADSTOOL MILLIONAIRES, p. 99.

[58] J. Marion Sims, in AMERICAN JOURNAL OF THE MEDICAL SCIENCES 23 (1852), p. 59; and THE STORY OF MY LIFE (New York: D. Appleton & Co., 1884). For McDowell see, ECLECTIC REPERTORY (Philadelphia), 7 (1817), p. 242, and 9 (1819), p. 546; James T. Flexner, DOCTORS ON HORSEBACK (New York: Viking Press, 1937), p. 143. On the ethical issues, see A. Scott Earle, SURGERY IN AMERICA (Philadelphia: W.B. Saunders, 1965), passim; Lloyd G. Stevenson, *The Emergence of American Medicine in the 19th Century,* CAHIERS D'HISTOIRE MONDIALE XI (1968) 3: pp. 455-66.

[59] Boland, THE FIRST ANESTHETIC.

[60] AMERICAN JOURNAL OF THE MEDICAL SCIENCES, 20 (1850), p. 398.

[61] Richard H. Shryock, MEDICINE IN AMERICA: HISTORICAL ESSAYS (Baltimore: Johns Hopkins Press, 1966), p. 167.

In at least one case, a Southern physician apparently insisted upon following the wishes of a slave patient, even when the law demanded that the master's conflicting demands be obeyed. In 1852, a Kentucky physician named Grimes prescribed some medicine at the request of a sick slave, despite the master's unwillingness to have the slave treated. When the treatment led to complications, the owner sued for malpractice.[63] Remarkably, the jurors upheld the doctor, after the circuit court judge instructed them to base their verdict on the intended *medical* outcome! "Although the jury may find Dr. Grimes administered medicine to the slave, he is not responsible, provided they further believe that, in his administering said medicine, he acted in good faith as a physician, for the purpose of curing the boy of disease." However, the master appealed the case to the state supreme court. In overturning the trial verdict, Justice Hise made clear that, in Kentucky at least, the law of slavery superceded the ethics of medicine. "A physician is responsible for all the ill consequences which may result from the administration of medicine to a slave without the consent of the owner."[64]

Anesthesia. Just as the law of slavery provides a dramatic example of how social systems influenced medical consent, the mid-nineteenth-century introduction of surgical anesthesia illustrates the effect on medical ethics of technological changes.[65]

The initial public testing of anesthesia clearly violated nineteenth-century standards of informed consent. Neither the patient nor the surgeons even knew the makeup of the "Letheon" gas being administered by Boston dentist W.T.G. Morton. The hospital case records originally omitted any mention of these early experiments; only after their success had been assured was an addition inserted to preserve the event for posterity.[66]

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[62] Savitt, MEDICINE AND SLAVERY, p. 288; for other incidents see pp. 289, 291. But note that not even the most concerned physicians ever questioned how "free" a *slave's* "consent" could be, given the great power of the owner.

[63] Hord v. Grimes, 52 Ky 149, 13 B. Monroe 188. Even here the action was for malpractice, though it would seem the owner had grounds for claiming trespass *vi et armis*.

[64] Hord v. Grimes.

[65] The following section will appear in a different form in Martin S. Pernick, A CALCULUS OF SUFFERING: PAIN, ANESTHESIA, AND UTILITARIAN PROFESSIONALISM IN NINETEENTH CENTURY AMERICAN MEDICINE (New York: Columbia University Press, forthcoming). This is a revised and expanded version of the Ph.D. dissertation of the same title, Columbia University, 1979. Citations to this work in this paper refer to the pagination of the dissertation.

But the new discovery had far more important long-range effects upon the patient's decisionmaking role in nonexperimental surgery. Anesthesia not only prevented pain; it also gave the surgeon complete control over the patient. Many nineteenth-century doctors unabashedly welcomed their new power. The use of anesthesia to circumvent informed consent requirements found many supporters in the medical press. One major surgery text taught that anesthesia's "benefits are not confined to the abolition of pain: . . . it circumvents the opposition of the timid and unruly." "It is, indeed, not an unheard-of thing that a surgeon's presence of mind should fail him in a difficult operation, even at the present day; but at least the patient, unconscious through the blessing of anesthesia, does not know it . . . to the great comfort of all concerned," recalled another surgeon in 1897.[67]

Nineteenth-century medical journals published without apology many case examples in which anesthetics enabled the surgeon to operate without the patient's knowledge or consent. One fascinating example from 1864 should be of special interest to contemporary bioethicists; in this case a chaplain assisted in performing the operation!

> Shubert absolutely refused to submit to amputation . . . On the twenty-first day after the injury . . . [e]very thing seemed to indicate a speedy and fatal termination of the case . . . "I wish," said he, "I had taken your advice at first, and had the leg off. . . ."
>
> Not wishing to increase the inevitable shock of the operation by any mental depression, I concealed from him my purpose, and told him I would put him to sleep, and perhaps the ball might yet be extracted . . . and without any suspicion he took the chloroform kindly, and was soon sound asleep. The attendants immediately came into the ward with the necessary instruments, &c., and I amputated . . . the femoral artery was admirably compressed by Rev. Mr. Scandlin, Chaplain of the 15th Mass. Vols., a high-toned gentleman . . . .[68]

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[66] Pernick, CALCULUS OF SUFFERING, pp. 62-69.

[67] Robert Druitt, THE PRINCIPLES AND PRACTICE OF MODERN SURGERY (new and revised American from the 8th enlarged and improved London ed.; Philadelphia: Blanchard and Lea, 1860), p. 592; THE SEMI-CENTENNIAL OF ANAESTHESIA (Boston: Massachusetts General Hospital, 1897), p. 29. For other examples see Pernick, CALCULUS OF SUFFERING, pp. 142-43.

[68] Reported by A. B. Crosby in TRANSACTIONS, New York Hampshire Medical Society (1864), pp. 38-39.

Anesthesia was especially lauded as a means of overcoming the resistance of those judged mentally or legally incompetent to give valid consent. Children and the insane were frequently mentioned examples. But many nineteenth-century Americans believed slaves, immigrants, and women also lacked the capacity to decide upon their own medical treatment. Thus, an article in the prestigious AMERICAN JOURNAL OF THE MEDICINE SCIENCES declared it "occasionally admissable, particularly in children," to involuntarily anesthetize troublesome patients—the "child" in this case was a "young lady, of highly cultivated mind, aged about 25 years. . . ." A Pennsylvania doctor recommended anesthesia for obstetrics "in cases where manual or instrumental assistance is imperatively demanded, and is strenuously resisted by the patient. . . ." The BULLETIN of the highly regarded New York Academy of Medicine presented the case reports of one obstetric surgeon who made it his "unfailing custom" to use ether so that he might operate on the woman "without making known to her the fact that forceps were to be used":

> Now, sir, in forceps cases, I find it the greatest pleasure in the world . . . to spare the patient the anticipation of the operation . . . Chloroform is of great advantage in enabling you to make a thorough examination of the child without the mother's knowing that you are doing so with reference to the operation. Another advantage consists in the fact, that you can have a consultation without her knowing it. She is spared the knowledge that Dr. A. or Dr. B is going to be brought: the doctor can come, perform the operation and retire, while the patient is utterly ignorant of what is being done.[69]

In many of the reported cases, the patients' refusal to permit an operation constituted the primary evidence that they were incompetent to make a rational decision. One early but typical example involved an Irish laborer brought to Massachusetts General Hospital in 1847 after having been hit by a train. Dr. J. Mason Warren determined that a thigh amputation was essential to save the man's life. The laborer however expressed his intention to die in one piece and became "much excited" at Warren's suggestion of surgery. Warren clearly considered the man's position irrational and ordered him put in a strait jacket. When that action failed to restrain him, he was forcibly anesthetized, and the limb removed. Two days later he died.[70]

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[69] AMERICAN JOURNAL OF THE MEDICAL SCIENCES 22 (1851), p. 498; Edward H. Horner, *Anaesthetics*, unpublished M.D. thesis, University of Pennsylvania, Philadelphia, February, 1855, p. 30; B. Fordyce Barker, *On the Use of Anaesthetics in Midwifery*, BULLETIN OF THE NEW YORK ACADEMY OF MEDICINE I (1862), pp. 295, 304, quoting Dr. George T. Elliot.

Not surprisingly, almost all the nineteenth-century surgical consent lawsuits discussed in this paper involved female patients. For a similar observation on early twentieth-century cases see Kelly, KANSAS LAW REVIEW, p. 415. While the nineteenth-century patient population as a whole was (and still is) disproportionately female, the midnineteenth-century operative surgical population was not; Pernick, CALCULUS OF SUFFERING, pp. 387-417.

For a revealing admission of the rage and sexual frustration evoked by the struggle between a twentieth-century doctor and a young female patient, see William Carlos Williams, *The Use of Force*, in THE FARMERS' DAUGHTERS: THE COLLECTED STORIES (New York: New Directions, 1961).

Despite the frequency and candor with which medical journals discussed such uses of anesthesia, very few cases found their way into nineteenth-century courts; those that did were decided upon medical grounds. One of the earliest cases was the 1866 British trial of Absolon v. Stratham. In this case, a seamstress alleged that Mr. Stratham, a surgeon, had forcibly chloroformed her and removed six of her teeth. She charged him with assault. In his defense, Stratham was allowed to present evidence that his conduct was medically necessary, skillful, and not negligent; and that the woman lacked competence to fully assess the need for surgery. In short, despite the charge of assault, the case was allowed to be tried by the medically based standards of malpractice. The jury (perhaps understandably) could not reach a verdict, and the practitioner went free.[71]

Virtually all such uses of anesthesia were justified by reference to the patient's supposed medical best interests as well as mental incompetence. In one extreme example, an Ohio prison surgeon accused of using anesthesia to perform unwanted operations argued that only a doctor could judge what was in the best interests of a prisoner.[72] But "competence" and "best interests" are in part value decisions. Nineteenth-century legal and medical doctrines, which made a patient's rights to information and choice contingent upon a medical assessment of the person's interests and capabilities, thereby institutionalized the values and the prejudices of the nineteenth-century medical profession. In a system that allowed medical standards to govern which patients would be allowed to participate in decisionmaking, many surgeons used the new anesthetic technology to expand their paternalistic authority over those patients whose health was deemed to require limiting their autonomy.

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[70] Massachusetts General Hospital Surgical Records, Volume 31, Admission of April 7, 1847. For similar cases see *ibid*. Volume 63, page 236 (January 24, 1855); Volume 65, page 18 (February 24, 1855); and Pernick, CALCULUS OF SUFFERING, pp. 426-30.

[71] Absolon v. Stratham, transcript published in LANCET (1866) part 2, pp. 561-64.

[72] Jonathan Dawson, *The 'Gross Outrage,'* OHIO MEDICAL AND SURGICAL JOURNAL 9 (1857), pp. 333-34.

However, there were physicians who opposed any use of anesthesia to circumvent patient autonomy. Doctors on both sides of the bitter debate over obstetric anesthesia insisted on the medical value of sharing information and decisionmaking with the patient. "I do not use any anesthetic of any kind, . . . " an Iowa physician declared in 1887. "I want the patient to know what is going on." The leading advocate of obstetric anesthesia, the Edinburgh surgeon James Y. Simpson, applauded the fact that his "ladies" insisted upon making the decisions about obstetric anesthesia themselves: "the ladies themselves will keep medical men right. . . ." Dr. J.F.B. Flagg of Philadelphia advised the husbands of expectant women that, if the obstetrician attempted to overrule the woman's request for anesthetics, "you had better put him in the next room with the rest of the children, and allow of no one to be present who cannot be useful." The American Journal of the Medical Sciences found it necessary to "deprecate violence of any kind" in the use of anesthetics.[73]

Popular fears of involuntary surgery became evident within a few months of the first anesthetizations. As early as 1847, a French cartoonist gave expression to such anxieties in a drawing that depicted a dental patient awakening to find all his teeth gone. Similar fears play an important role in several turn-of-the-century novels by Frank Norris.[74]

The extent to which anesthesia prompted gross violations of patient autonomy should not, however, be exaggerated. The examples discussed show that anesthesia was used to perform operations without the patient's consent and that such surgery had considerable professional and legal sanction. But at least some surgeons opposed these infringements of patient autonomy. And it is easy to find counter-examples, cases in which a patient who refused anesthesia and/or surgery was allowed to have his or her (but usually his) own way.[75] As isolated instances, these examples do not really tell us whether or not anesthetics led to any increase in the overall amount of involuntary surgery actually performed. The total number of blatantly forcible procedures done at the major nineteenth-century American hospitals remained small, both before and after 1846. Medical journals did publish more such cases after 1846, but the rise in reporting seems due to the journalistic novelty of anesthesia rather than to any sudden epidemic of force. And the victory over pain almost certainly made more patients willing to voluntarily consent to undergo medically indicated surgery.

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[73] John Duffy, *Anglo-American Reaction to Obstetrical Anesthesia*, Bulletin of the History of Medicine, 38 (January-February, 1964), p. 43; Simpson to Francis Ramsbotham, August 15, 1853, Francis Henry Ramsbotham Paper, National Library of Medicine, Bethesda; J. F. B. Flagg, Ether and Chloroform (Philadelphia: Lindsay and Blakiston, 1851), pp. 127-28, x; American Journal of the Medical Sciences 22 (1851), p. 495; for additional examples see Pernick, A Calculus of Suffering, pp. 101-104.

Medical concern for protecting patient consent at other times sprang from other motives, such as the desire to protect the profession against accusations of rape, robbery, and recklessness; charges which proliferated almost immediately after the introduction of anesthetics.

[74] Cartoon reprinted in Journal of the History of Medicine and Allied Sciences, I (October, 1946), p. 611; Norris, A Man's Woman (New York: AMS Press, 1970), McTeague (New York: Holt, Rinehart & Winston, 1950).

Anesthesia clearly did eliminate the patient's ability to make decisions about those events that might arise during the course of the operation itself. Unanesthetized patients had enjoyed an almost unlimited freedom to express their opinions during surgery and to make known their desires about what should be done to their bodies. However, the practical importance of this freedom was much less than it might seem. Once a patient had agreed to begin an operation, the professional canons of pre-anesthetic surgery demanded that the doctor complete the procedure, no matter how strenuously the patient attempted to change his or her mind. The pain-racked patient was assumed to be *non compos mentis* during the operation; the surgeon was no more bound to heed the desires of a patient on the table than he was those of a raving lunatic. Burly assistants were always kept at hand to overcome resistance. Occasionally an agonized sufferer would break free, only to be physically subdued by the doctors. One such escapee, attempting to resist an operation by the eminent British surgeon Robert Liston, locked himself in the lavatory. Liston reportedly forced the door and personally hauled the struggling man back to the table.[76]

The use of anesthesia clearly reduced the power of patients to make their wishes heard; it did not necessarily effect their ability to have their decisions heeded. As late as 1880, one New York judge ruled that no patient could be considered competent once even the initial preoperative procedures had commenced. "Judge Russell stated in his charge that . . . the patient under the excitement of an impending operation was not competent to revoke any authority previously given."[77] Not until the 1880s did the inability of anesthetized patients to participate in mid-operative decisions come to be seen as posing legal or ethical problems.[78]

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[75] For example: Massachusetts General Hospital Surgical Records, Volume 31, Admission March 12, 1847; Pennsylvania Hospital Fracture Books, Thomas K., Admission September 5, 1853; Frank H. Hamilton Case Books, National Library of Medicine, Bethesda, Volume 6, Thomas W., February, 1857; Hamilton Case books, Volume 12, Mrs. R., p. 38; Hamilton Case Books, Thomas K., September 5, 1853.

[76] Betty MacQuitty, THE BATTLE FOR OBLIVION (London: George G. Harrap & Co., Ltd., 1969), p. 94. For the Hippocratic precedents see Edelstein, *Professional Ethics*, p. 80. For nineteenth-century American examples see AMERICAN JOURNAL OF THE MEDICAL SCIENCES 24 (1852), p. 43; OHIO MEDICAL AND SURGICAL JOURNAL 9 (1857), p. 334.

The long-term effects of anesthesia on patient decision-making have been the most subtle and the most pervasive. Today, many people rely upon painkilling technology to provide a pill or panacea for every discomfort. This modern reliance on medical expertise to provide a "technical fix" for every pain has resulted in a subtle loss of individual autonomy. Painkillers have fostered our dependence upon medical experts. In addition, the discovery of anesthesia seemingly launched us down an infinitely expanding demand curve—the relief of some pains leaves us more exquisitively sensitive to those pains that remain. As William Lawrence, Episcopal Bishop of Massachusetts at the end of the nineteenth century put it, "The blessing of anesthetics has so released humanity from the awful terrors of pain that we cannot endure even the thought of what our fathers passed through."[79]

A few nineteenth-century physicians and lay leaders, such as the French physiologist Francois Magendie and the American feminist Elizabeth Cady Stanton, rejected the use of anesthetics because they feared the dehumanizing loss of patient control. Stanton urged women to reject obstetric anesthesia in order to take "the liberty of being her own physician."[80]

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[77] *The Patient's Consent to an Operation and the Surgeon's Discretion*, THE MEDICAL RECORD (New York) 18 (December, 1880), p. 715. The jury is stated to have "disagreed" with these instructions, but still voted for acquittal.

[78] In Mohr v. Williams 95 Minn 261, 104 N.W. 12 (1905) the court seemed to hold that patients should be consulted about mid-operative decisions to expand the scope of the operation (except in emergencies). However, in Bennan v. Parsonnet, 83 N.J.L. 20, 83 Atl. 948 (1912), and McGuire v. Rix,118 Neb. 434, 225 N.W. 120 (1929), this obligation was removed. For further comments, see Kelly, KANSAS LAW REVIEW, pp. 413-14.

[79] The basic argument is presented by Ivan Illich, MEDICAL NEMESIS (New York: Pantheon Books, 1976). While I can agree with many of Illich's observations, his analysis of the origins of these problems in a professional conspiracy is historically unfounded; see Pernick, A CALCULUS OF SUFFERING, esp. p. 435. For Bishop Lawrence, see OUTLOOK 76 (1904), p. 873, quoted in James Turner, RECKONING WITH THE BEAST: ANIMALS, PAIN, AND HUMANITY IN THE VICTORIAN MIND (Baltimore: Johns Hopkins University Press, 1980) p. 82.

[80] Elizabeth Cady Stanton to Lucretia Mott, October 22, 1852, reprinted in THE OVEN BIRDS: AMERICAN WOMEN ON WOMANHOOD, 1820-1920, ed. by Gail Thain Parker (Garden City: Anchor Books, 1972) p. 260. For

Unlike Stanton, most nineteenth-century Americans seem to have been all too eager to surrender their freedom in exchange for relief. Our present dependence on painkillers occurred because of lay demands to escape suffering, not because of a professional plot to deprive us of our autonomy. Nineteenth-century physicians complained repeatedly that their patients insisted upon pain relief above all else, even contrary to professional advice. It was the public, not the medical profession, who insisted that doctors cure every ache and pain, regardless of the price of autonomy.[81]

In summary, nineteenth-century American medicine had its own therapeutically based standards of informed consent, justified by a holistic belief in the direct impact of autonomy on health. Courts generally chose to enforce such medical standards, rather than to assert a patient's right to absolute personal autonomy. This policy permitted the individual medical needs and decisionmaking abilities of each patient to be taken into account. But it also made personal autonomy subordinate to medical values and protected an individual patient's choices only when such decisionmaking would not be injurious to that patient's health.

From Malpractice to Battery: Informed Consent, 1890-1920

Beginning in the 1890s, American courts were beseiged by patients who claimed to be the victims of involuntary surgery. Unlike most prior complainants, these patients often charged their doctors with battery, not just malpractice.[82]

The best known of these cases was Schloendorff v. Society of New York Hospital. In this 1914 case, Justice Cardozo proclaimed a memorable affirmation of a patient's right to self-determination, regardless of the medical consequences of such choices. "Every human being of adult years and sound mind

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Magendie, see Rene Fulop-Miller, Triumph Over Pain (New York: Literary Guild of America, Inc., 1938), p. 211; J. M. D. Olmsted, Francois Magendie (New York: Schuman's, 1944), pp. 244-47.

[81] Semi-Centennial of Anaesthesia, p. 53; Western Lancet, 7 (1848), p. 364; John Wesley Thompson, *Anaesthesia*, unpublished M.D. thesis, University of Pennsylvania, Philadelphia, January, 1860, all make this observation. For examples of medical complaints without the causal analysis, and a much fuller development of this point, see Pernick, Calculus of Suffering, pp. 426-37.

[82] Battery was not the only new action in which informed consent cases were adjudicated in this period. Other theories under which a few such cases were brought included fraud and even false imprisonment. See Kelly, Kansas Law Review, p. 410; Katz, Experimentation, p. 604.

The earliest reported American battery case located is Janney v. Housekeeper, 70 Md. 162, 16 AH 382 (1889).

has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault. . . ."[83] The Schloendorff ruling cited two recent Midwestern precedents, Mohr v. Williams (1905) and Pratt v. Davis (1906).[84] In the latter decision, the Illinois court had ruled that

> . . . under a free government at least, the free citizen's first and greatest right, which underlies all others—the right to himself—is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent . . . to violate without permission the bodily integrity of his patient by . . . operating on him without his consent. . . .[85]

The justices' attempts to ground their rulings in ancient common law principles successfully obscured the extent to which early twentieth-century decisions involved new and unprecedented legal practices. Despite the hoary antecedents of battery law, it was rarely if ever applied in practice to American medical consent cases prior to 1889. The ringing prose of Cardozo and his colleagues led most legal scholars then and since to overlook the extent to which the battery theory of informed consent was an innovative response to unprecedented social and medical conditions.

To understand the origins of this striking legal innovation, it is necessary to examine the dramatic medical and social changes in progressive-era America. Within medical science, European discoveries in bacteriology, immunology, genetics, and chemotherapy first revealed the power of a medical science firmly grounded in specific rather than holistic paradigms. Where nineteenth-century medical science had proved that ill health was correlated with poverty, filth, malnutrition, and constitution, Louis Pasteur and Robert Koch proved that dozens of specific diseases were caused by single specific microbes. This new scientific reductionism undercut the earlier medical view that a person's entire moral, social, and mental environment directly influenced his or her state of health.[86]

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[83] 211 N.Y. 125, at 127; 105 N.E. 92.

[84] Mohr v. Williams, 95 Minn. 261, 104 N.W. 12; Pratt v. Davis 224 Ill. 300, 79 N.E. 562.

[85] 224 Ill. 300.

[86] Rosenberg, *Florence Nightingale on Contagion*; Rene Dubos, MIRAGE OF HEALTH (New York: Harper & Row, Publishers, 1959); Martin Kaufman, *The American Anti-Vaccinationists and Their Arguments*, BULLETIN OF THE HISTORY OF MEDICINE 41 (September-October, 1967), pp. 463-78; Turner, RECKONING WITH THE BEAST, Chap. VI; Edmund Pellegrino, *The Sociocultural Impact of Twentieth Century Therapeutics*, in THE THERAPEUTIC REVOLUTION, ed. by Morris Vogel and Charles Rosenberg (Philadelphia: University of Pennsylvania Press, 1979), pp. 245-68.

Nineteenth-century doctors and lawyers had based their beliefs about informed consent on the assumption that a person's information and autonomy could directly affect their physical well-being. But, as medical science increasingly shifted its attention to microscopic germs (and later genes, vitamins, hormones, etc.), such earlier concerns could be lumped with "psychosomatic" illness, at the periphery of legitimate medical concern. Informed consent issues thus could be safely relegated to the lawyers and philosophers, as medical science no longer considered such matters so central to the actual causation of health and disease. The battery theory of medical consent, which guarantees patient autonomy without regard for the medical effects, was adopted at precisely the same time as physicians were concluding that autonomy in itself had no direct causal influence on health and sickness. Of course, the *substance* of the patient's decisions was still recognized as affecting the medical outcome; but the *acts* of receiving information and making decisions were no longer seen as medically significant. Even Richard C. Cabot, one of the more holistic leaders of early twentieth-century medicine, commented on "[t]he astounding *innocuousness of the truth* when all reason and all experience would lead one to believe it must do harm. . . ."[87]

But this growing dichotomization of "science" and "values" in medicine did not mean that society adopted a laissez-faire attitude towards expert advice. Quite the opposite occurred. Popular faith in the wisdom and objectivity of science led to a veritable cult of professional expertise. Many progressive-era social reformers regarded scientists as virtual philosopher-kings; impartial and efficient experts who would guide and preserve democracy from the twin evils of ignorance and greed.[88]

Medicine, perhaps more than any other profession, both inspired and benefited from this new deference to the man in white. The reimposition of medical licensing laws, the education reforms and restrictions advocated by Abraham Flexner, and similar developments all vastly increased the power and prestige of organized medicine. Rival medical sects died out or were driven underground; the number of regular medical graduates was cut drastically.[89]

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[87] Richard C. Cabot, *The Use of Truth and Falsehood in Medicine: An Experimental Study*, AMERICAN MEDICINE 5 (1903), pp. 344-49, reprinted in Reiser, et al., ETHICS IN MEDICINE, pp. 213-20, p. 217.

[88] Robert Wiebe, THE SEARCH FOR ORDER, 1877-1920 (New York: Hill & Wang, 1967); for examples see Frederic C. Howe, WISCONSIN, AN EXPERIMENT IN DEMOCRACY (New York: Charles Scribner's Sons, 1912); Walter Lippmann, DRIFT AND MASTERY (New York: M. Kennereley, 1914); and PUBLIC OPINION (New York: Harcourt, Brace and Company, 1922).

It seems reasonable to regard Schloendorff and similar decisions as at least in part motivated by the attempt to preserve some balance between the patient and the doctor in the face of this rapidly expanding professional monopoly. The suppression of medical sectarianism and the restriction of the number of practitioners eliminated many of the *de facto* choices and powers of nineteenth-century patients. Thus, many conflicts that probably would have been resolved extrajudicially in the nineteenth century began to appear in progressive-era courtrooms.

The creation of a medical monopoly was neither the only nor the most direct threat to individual patient autonomy in this period. In the name of social utility, turn-of-the-century American legislatures adopted unprecedented measures to give medical experts the authority to treat certain classes of competent patients against their will. The history of such involuntary therapy began with smallpox vaccination. Although Jenner's discovery had reached America in the 1790s, many more or less rational arguments led to substantial anti-vaccination sentiment throughout the nineteenth century.[90] Quarantine laws could compel a sick person to be isolated, but no legal authority existed to require the vaccination of a competent, healthy adult.[91]

In the 1905 case of Jacobson v. Massachusetts, however, the United States Supreme Court first upheld a state law mandating smallpox vaccination regardless of patient consent. This landmark ruling was neither simply a long-overdue tribute to Jenner nor an isolated legal fluke. Based on this precedent, American courts upheld the extension of police powers for a variety of medical purposes, from compulsory vaccination with untested flu vaccines in 1918 to compulsory sterilization of the retarded in 1927.[92]

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[89] There has yet to be a satisfactory comprehensive history of these changes. See Rothstein, AMERICAN PHYSICIANS; James G. Burrow, AMA: VOICE OF AMERICAN MEDICINE (Baltimore: Johns Hopkins Press, 1963); Susan Reverby and David Rosner, eds., HEALTH CARE IN AMERICA (Philadelphia: Temple University Press, 1979).

[90] Kaufman, *Anti-Vaccinationists.*

[91] However, in the case of O'Brien v. The Cunard Steamship Lines 28 N.E. 266 (1891), the courts refused to uphold the battery charge made by an arriving immigrant who claimed to have been vaccinated against her will. The decision implied that the vaccination of immigrants was not involuntary since they had the option to go back to where they came from.

[92] Jacobson v. Massachusetts, 197 U.S. 11; Alfred Crosby, EPIDEMIC AND PEACE 1918 (Westport, Conn.: Greenwood Press, 1976); Buck v. Bell 274 U.S. 200.

It has not been noted by legal scholars, but the Jacobson decision

The conflict between the absolutist defense of patient autonomy in Schloendorff and the unprecedented medical control approved in Jacobson reflected the ambivalence and conflict within progressive-era society about the role of experts in a democracy. While John Dewey spoke for those who sought to buttress individual autonomy through education, Walter Lippmann became the publicist for those who advocated expanding the directive role of technical experts. In every sphere of public policy, from pure foods to prohibition, the conflict between the educative and the regulative functions of experts marked the progressive-era approach to reform.[93]

The tension between the Schloendorff and Jacobson decisions anticipated the conflicting values expressed at the climax of Aldous Huxley's BRAVE NEW WORLD (1932).

> "But I don't want comfort. I want God, I want poetry, I want real danger, I want freedom, I want goodness, I want sin."
>
> "In fact, said Mustapha Mond, "you're claiming the right to be unhappy."
>
> "All right then," said the Savage defiantly, "I'm claiming the right to be unhappy."
>
> "Not to mention the right to grow old and ugly and impotent; the right to have syphilis and cancer; the right to have too little to eat; the right to be lousy; the right to live in constant apprehension of what may happen tomorrow; the right to catch typhoid; the right to be tortured by unspeakable pains of every kind." There was a long silence.
>
> "I claim them all," said the Savage at last.
>
> Mustapha Mond shrugged his shoulders. "You're welcome," he said.[94]

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rested on totally invalid medical reasoning. In effect, the Jacobson court justified compulsory treatment by arguing that the unvaccinated posed a direct threat to the public's health. But this was simply not true. The unvaccinated might have been a threat to the *pocketbooks* of the voluntarily vaccinated majority (as was admitted in the case of Buck v. Bell), but the unvaccinated were only a *health* threat to each other, not to the public at large.

While several legal theories could have been used to get around this difficulty, the court simply ignored or misunderstood Jacobson's argument on this point. The Jacobson court was less concerned with establishing what the scientific facts were than it was with empowering scientific experts to solve social problems.

[93] Martin S. Pernick, *The Ethics of Preventive Medicine: Thomas Edison's Tuberculosis Films: Mass Media and Health Propaganda*, HASTINGS CENTER REPORT 8 (June, 1978), pp. 21-27 presents these issues in greater detail.

[94] Aldous Huxley, BRAVE NEW WORLD (New York: Bantam Books, 1960, 1932), p. 163.

The rise of medical battery law can reasonably be interpreted as one side of a progressive-era dialectic on the basic questions of expertise and democracy. Schloendorff and Jacobson were opposite walls of the same house, the two outer limits within which progressive-era Americans debated their response to the unprecedented changes in science and society.

Epilogue: Consent Since *Salgo*

Postwar revelations of shocking domestic medical experiments and medical genocide abroad combined with the rebirth of organized reform movements in the 1960s to provide the immediate setting for the emergence of modern informed consent doctrines, beginning with the Salgo case in 1957. Initially, modern informed consent cases drew upon the battery theory so clearly enunciated by Cardozo in 1914. This approach can be seen as a continuation into the penicillin era of the sharp progressive dichotomization of medical technology and medical ethics, and the turn-of-the-century ambivalence about the role of expertise.

But throughout the twentieth century, a few important medical scientists continued to promote holistic theories of disease, medical approaches that kept alive the concept that a person's autonomy could directly influence their health. And, as in the nineteenth century, physicians who adopted such holistic paradigms tended to regard informed consent as a therapeutic, not a legal, obligation. Thus one of the most illustrious advocates of twentieth-century holistic medicine, L.J. Henderson, believed that truth-telling could hurt or heal a patient as directly as could a scalpel.[95] Based on such theories, a minority of American courts in the first half of this century continued to treat surgical consent cases as malpractice, not battery.[96]

The 1970s and 1980s have seen a much-publicized disillusionment with technocratic medicine, and a revival of "holistic," "natural," and "psychosomatic" theories that supposedly stress the integration of life-style, environment, mind, and body. And as society has begun to rediscover such older medical ideas, our courts have begun to revive the idea that patient autonomy ought to be judged in terms of its effects on patient health. Although most modern courts are totally unaware of the nineteenth-century precedents, the current trend towards treating consent issues as malpractice cases bears a striking similarity to nineteenth-century opinions. In one of the most recent such cases, Wooley v. Henderson (1980) the Maine court virtually restated the 1853 decision in Twombly v. Leach:

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[95] NEW ENGLAND JOURNAL OF MEDICINE 112 (1935), p. 819.

[96] Kelly, KANSAS LAW REVIEW, p. 410 cites two Colorado examples from 1929 and 1954, but is unaware of the nineteenth-century precedents, and so regards Colorado as distinctive.

> In determining whether and how much he should disclose, physician must consider probable impact of disclosure on patient. . . . Conceivably, full disclosure by physician under some circumstances could constitute bad medical practice.[97]

Any application of battery law to informed consent issues has become extremely controversial, especially in the area of drug therapy. In the 1980 case of Malloy v. Shanahan, the Superior Court of Pennsylvania ruled that prescribing drugs did not involve "touching" the patient. Thus the justices decided, two to one, that the doctrine of informed consent "has not been extended to therapeutic treatment" outside surgery.[98] On the other hand, the United States District Court for Northern Illinois has ruled that battery actions can be brought in cases where drugs were given without informed consent.[99] The future use of battery as a grounds for informed consent seems very likely to be quite circumscribed.

The current trend towards reviving malpractice as the primary basis for informed consent is not simply the result of legal capitulation to the medical profession; it reflects instead the change from technocentric to more holistic approaches within medicine and society.[100] The malpractice-based standards of informed consent take into account the newly rediscovered impact of information, decisionmaking, and autonomy on individual health. But health is not the only legally or ethically important human value. The historical example of the nineteenth century reveals all too clearly that violations of patient autonomy can be legitimated in the name of holistic benevolence as well as in the name of technical expertise. As we revise our policies to recapture the nineteenth century's holistic concern for health, we must continue to provide safeguards against the revival of nineteenth-century abuses.

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[97] 418 A. 2d 1123. See also Hunt v. Bradshaw 242 N.C. 517, 88 S.E. 2d 762 (1955).

[98] 421 A. 2d 803.

[99] Mink v. University of Chicago, 460 F. Supp. 713 (1978), at 717. I am extremely grateful to Marie Deveney of the University of Michigan Law School for help in tracking down the materials in notes 97-99, and to Christine Whitman of the University of Michigan Law School for providing this citation.

[100] The argument for this as the result of legal surrender to doctors is presented most strongly in Katz, *Informed Consent*. While I agree with Katz's analysis of the dangers in a malpractice standard, I disagree with his version of how and why such standards were reinstituted.

One popular 1981 medical book presents the holistic theory that laughter can help fight disease. Written by cardiac surgeon Ted Goen, the work entitled SMILE OR I'LL KICK YOUR BED.[101] I for one would not want Dr. Goen as my physician without the protection of an informed consent doctrine based on something besides the malpractice standard.

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[101] (New York: W.W. Norton, 1981).

[illegible]

[illegible] physician [illegible] on patient. [illegible] Consequently, "nondisclosure" by a physician under some circumstances could constitute bad medical practice.

Any application of battery law to informed consent issues has proven extremely controversial, especially in the area of drug therapy. In the 1980 case of Malloy v. Shanahan, the Superior Court of Pennsylvania ruled that prescribing drugs did not involve "touching" the patient. Thus the justices decided, two to one, that the doctrine of informed consent "has not been extended to therapeutic treatment" outside surgery. On the other hand, the United States District Court for Northern Illinois has ruled that battery will lie [illegible] where drugs were given without informed consent. The future role of battery as a remedy for informed consent seems very likely to be [illegible].

The current legal [illegible] as the primary basis for informed consent is not simply the result of legal [illegible] to the medical profession; it reflects instead the change from [illegible] approaches within medicine and society. [illegible] century reveals all too plainly that violations of patient autonomy can be [illegible] in the name of [illegible] as well as in the name of [illegible]. As we revise our policies to [illegible] century's [illegible] concern for health, we must continue to guard [illegible] against the revival of [illegible] century ethics.

[illegible] A. 2d 1121. See also Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d [illegible]

[illegible] A. 2d 848.

[illegible] University of Michigan [illegible] the University of Michigan Law School [illegible]

[illegible] W. W. Norton, 1981.

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Culture and Informed Consent: An Anthropological Perspective

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Introduction

In this essay I explore the anthropological bases of "informed consent" in the therapeutic relationship.** I examine briefly the nature of the anthropological concept, "culture"; in the cultures of different societies, "informed consent" may be very differently understood, valued, and communicated. I examine informed consent as an event and as a possible outcome of communication between two parties, each situated in a cultural setting that may differ from the other's to varying degrees. I then explore the understandings, values, and communication rules prominent in several cultures, in order to test the fit of informed consent within them. I begin with "core American" culture, turn to the "sub-culture" found in American medicine, and then review briefly the cultures of Vietnamese refugees, Puerto Rican mainlanders, Navajos, and Italian Americans. A summary of these versions shows a profound contrast, indeed a conflict between the American medical sub-culture and the other cultural groups reviewed; the conflict is implicated in contemporary difficulties in American medicine, not only with regard to informed consent, but with much broader issues as well. I propose several reforms in the arrangements of our medicine.

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**Throughout the discussion I use the term, "therapy," in a broad sense, to include diagnosis, curative and preventive procedures, and "after-care" or "follow-up" measures. I speak of "patients," including parties who, under some circumstances, may be the representatives for the designated patient, and of "physicians" or "healers," including those persons who act with, on behalf of, or instead of the physician or other therapist; for example, nurses and technicians of various sorts. "Informed consent" should be broadened to include informed refusal, thus "informed decision." My discussion focuses on therapeutic relations in the dominant medical institution of our society, biomedicine; a similar analysis could be made of other therapeutic forms.

Culture, Illness, and Communication

In order to formulate the ways in which differences between patient and healer affect the understanding and communicational processes of informed consent, I introduce the anthropological notion of "culture." Briefly, I define a culture as "the ordered set of beliefs, values, and rules of conduct held by the members of a society." The beliefs, values, and rules found within a society may be more or less consistent with each other; and the members of a society may partake in their "shared" culture to differing extents. Included in a society's culture, often overlapping, are its legal system, its religion, its science and medicine, its technology, and its economy. In the understanding of a given person's beliefs and behavior, knowledge of his or her cultural roots serves as an essential, though not exclusive guide. Anthropologists are often concerned with the workings of cultural sharing and conflict and with the relations of these to social events and the natural environment.

A society's culture identifies the general way its members think and feel. It specifies guidelines for their own behavior, at the same time providing the standards by which they evaluate each other's behavior. It characterizes the way in which societal members divide up "the world," and it tells how the parts are put together, how they work, how they are known, and what is good, bad, beautiful, ugly, and indifferent. It defines, if you will, the totality of "information" prevalent in a society. But note that "information" here is not simply the array of isolated facts, the "bits" of cybernetics. Far beyond such an array, a culture is an integral system that defines what counts as fact, as well as how such facts are esteemed; it is a whole fabric. What is information to one cultural system may be tangential, irrelevant, or contradictory to another, and radical translation may be required to convey information or sense from one culture to another. As a cultural participant, the patient, like the healer, is far from a *tabula rasa* on which information can be imprinted in direct fashion. Beginning at birth human tabulae are complexly inscribed in ways that differ systematically from society to society; systematic decoding is required for mutual understanding.

The culture of a society affects the health, pathology, and healing of its members in several interrelated ways, some of which directly, and others indirectly, define the possibilities and limits of informed consent.

The Cultural Definition of Medical Reality. A society's culture specifies its nosology, etiology, and theory of healing; that is, a culture divides up the conditions of health and disease that people are thought to undergo, the putative causes of such states, and the means of their alteration. More broadly, a culture defines the divisions of things and the workings of causal and other forces in the universe. Causes may be seen as located within persons, in relations between persons, or in "natural" or "supernatural" entities or forces. Thus, persons may be regarded as themselves responsible, partly responsible, or not responsible (i.e., as "patients," bearers of affliction) for their diseased states and/or their health; similarly, healers may be regarded as personally responsible, partly responsible, or only as the vehicles of greater forces in healing.

Such differences of conception and belief greatly affect the course of the therapeutic relationship. A patient who presents himself or herself in a medical setting with a complaint of pain or suffering wishes to have his or her problem alleviated. But the presentation itself and the source, nature, and consequence of the problem may be understood by the patient in a fashion very different from the physician's understanding; what counts as relief may also be differently understood. The patient's understanding will guide his or her response to the physician's acts and expressions (Chrisman 1977), as the physician's understanding guides his or her responses to what is taken to be "the patient's problem."

Two essential notions in the definition of "informed consent," namely "competence" and "rationality" (which may itself be an element of competence), must each be understood in two culturally specific senses. Firstly, being competent is being competent in the activities appropriate to one's cultural system, and being rational is logically or otherwise consistently following the premises of one's culture. A middle-class American may appear incompetent in traditional Navajo life, as a traditional Navajo may appear irrational in middle-class American ways of thought. The characteristics that constitute "the reasonable man" in one society need not do so in another society.

Secondly, "competence" and "rationality" may be conceptual elements of different cultural systems, and may be valued in those systems in ways which differ from our own. In Spiritist healing among Puerto Ricans, for example, the trance state is valued above rationality as a source of diagnosis and therapeutics. Such differences must be taken into account in understanding the reactions of patients to medical treatment, their relations with physicians, and informed consent. The physician's "logic" may not be sufficient to dissuade traditional belief, which nevertheless must be taken into account.

Similarly, patients who regard causality as widely dispersed in the universe, that is as not localized in either patient or healer, may not believe in "voluntary" action. Moreover, they may consider the disclosure of information as irrelevant, if not as blasphemous, meddling in cosmic process. Decisions about competence in what we regard as common human function may likewise be regarded as misplaced judgment of the mysterious cosmic distribution of qualities or characteristics to human actors. It is by no means universally believed that all persons are created equal. In these ways, informed consent may violate the cosmic forces of healing.

Culturally shaped notions of causality are relevant to informed consent in another way. In informed consent, it is expected that the patient will be told of likelihoods and susceptibilities—the probability that an outcome will or will not result, and that alternative approaches will have different outcomes. Likelihood is variously understood, even (if not especially) among probability theorists, but more broadly within our own society. (In any case, Kahneman and Tversky [1982] have shown how physicians as well as others do not follow the logic of probability in the way they make decisions). In other societies, the notion of likelihood may not be "understood" at all; or rather, this notion may contradict the local understandings. It has been claimed, for example, that the systems of thought found in many technologically simpler societies are deterministic. In such systems, while perhaps not all known or predictable, all events are definitively ordered; chance has no place. When members of these societies engage in our medical system, it is not clear what meaning information about risks and probabilities has or how such information might be presented in a more culturally appropriate fashion.

Such cultural differences of world view and conception of health and healing have further implications for the possibility of informed consent. If a patient is to be informed about medical procedures and outcomes, the information must clearly be phrased in an idiom that is congruent with his or her cultural understanding. Such translation requires that the physician be informed of the patient's understanding. Thus, while the information given by physician to patient may be of a different nature than that given by patient to physician, the informational process required for truly informed consent is a reciprocal one. To the extent that such exchange does not take place, medical practice remains impersonal and parentalistic.

The Cultural Determinants of Disease. A society's culture tells its members how to conduct their lives—what work to do, where to live, who to marry, what to worship, and so on. A society thus prescribes and allocates roles of responsibility for the conditions of self and other. While a society's members, for various reasons, will not always conform to their own rules, at least some conformity of rule and behavior is likely. Thus, a society's culture will map out the distribution of its members in time, space, and activity. In this distributional function, a society's culture will be responsible in various ways for disease. It will physically distribute pathogens through human and other carriers, thus spreading or preventing the spread of diseases. It will further engage society members in tasks that are healthy or pathogenic, or healthy in some ways and pathogenic in others. Such culturally produced disease includes both physical and more psychiatric states.

The Cultural Determinants of Healing. By prescribing the allocation of physical and social resources, a society's culture will also distribute physical and social sources of healing to its members. It will tell members how healers should achieve the powers they have, how they should use these powers, and how patients and their consociates should behave; for example, under what conditions they should consult healers of this type or that, and how they should respond to what they are told. While the prescribed behaviors may not in fact produce the healing they are supposed to, they may nevertheless conform to the members' beliefs about proper healing. (Discordance between belief and outcome occurs in our own society as well as elsewhere. See, for example, Preston, *Coronary Artery Surgery* 1977). Culture thus describes and prescribes a system of therapy.

The therapeutic system prescribed by a society's cultural system tells patients what to expect in the healing context. The Bostonian's culture tells the Bostonian what to expect when he or she visits a private physician, or when he or she enters the hospital for an operation. The Navajo's culture tells the Navajo what to expect when consulting the hand trembler as a diagnostician, and when having a sand painting performed by a prescribed healer. Where people participate in plural cultural systems, they may have expectations about healing settings not only in their own, but in foreign societies as well. These expectations or assumptions are clearly essential to the definition and limits of informed consent. Information and/or consent may themselves be expected or not, along with certain forms of therapy and broader relations with the healer.

The Cultural Determinants of Communication. Not only do cultures maintain very different sorts of "information," but they communicate this information in different ways as well. Beyond the grammar of its language, a culture contains rules about the etiquette of speech. Anthropologists and others have distinguished several ways in which rules of expression and communication may differ: topic, context, and manner. Certain topics are legitimate, others less so or forbidden; the legitimacy of topics may change in different contexts, with the contexts specifying place, persons, and other conditions under which certain kinds of talk are permitted or desirable while others are not. A culture also may prescribe the manner in which information is to be conveyed; manner may vary also for different topics and in different contexts.

Differences in rules of communication are essential in the process of information and the event of consent. Effective information requires not only address in the recipient's language and current conceptualization, that is, his or her own culture, but address also in a manner that does not violate, but that is compatible with, the recipient's rules of communication. Consent must likewise be understood. What appears to be consent may rather be approval of the social event, deference to perceived authority, or fear or lack of interest in further questioning. We are so accustomed to our own ways of communication that we take these as natural rather than as social conventions. In violating such conventions we inform improperly if at all; we misinform.

Striking differences of cultural information, values, and rules of communication are most apparent across great cultural distances; for example, between middle-class America and aboriginal Amazonia, or between historical and even contemporary China. It is important to emphasize that differences exist also within societies, especially within such historically complex ones as our own. The differences appear not only between middle-class America and American ethnic minorities—Native Americans, Italian Americans, or Vietnamese refugees—but also within segments of the more assimilated, traditional American culture. Intellectual and non-intellectual segments of the society may be distinguished from each other as sub-cultural groups, as might professions from one another and socio-economic strata from each other. (See, for example, Shostak and Gomberg 1964.) Even within professions, variation might be found. For example, while the medical profession is often regarded as monolithic, it is important for an understanding of informed consent to distinguish among medical specialists. Surgeons, internists, and pediatricians have distinct dialects as well as shared language and concomitant understandings of the world and proper procedure within it.

The examination of greater cultural differences clarifies processes that are universal in communication between any person and someone else.

Though I will not discuss it further here, it should be noted that pathological conditions of both physiological and more psychiatric types may affect the cultural capacities (i.e., competence) of knowledge and its communication. Such effects are more appropriately discussed by psychiatrists attuned to problems of communication. Patients may either lose or have altered aspects of their knowledge and/or their ability to express it. Such alterations may change understanding even across the smallest of cultural differences. They must be addressed to achieve significant informed consent.

Cultural Versions of Informed Consent

In this section I define the elements of informed consent. I present informed consent as an event of communicational exchange rather than as a predominantly one-way transfer of information. This definition forms the basis for the subsequent schematic sketches of cultural groups found within American society. To the extent that research findings are available, I present four components in each cultural sketch:

(1) The cultural *understanding* of the elements of informed consent; for example, theories of pathology and healing, and notions of "voluntary," "rationality," and "information."

(2) The cultural *valuation* of matters relevant to information and consent in the therapeutic setting: that is, cultural interest in or desires regarding interpersonal relations, the disclosure of information by a healer, and corresponding consent or rejection.

(3) The *communicational rules* appropriate to the therapeutic setting, in which the process of information and consent must be understood.

(4) In summary, the *cultural bases of informed* consent.

The cultural sketches must be read as tentative. They are based mostly on second- or third-hand reports that are directed to other questions. Cultural attitudes regarding informed consent would be difficult to discover even if directly researched. Based on issues of will and choice, knowledge and its sources, and the fundamental elements of disease and health, the matter of informed consent lies at the heart of a society's culture; such premises may underlie much of a people's behavior and expressions, yet remain deeply buried and difficult to discern without the observer's distanced familiarity. My inferences regarding the cultural attitudes toward informed consent are thus oblique, built on tangential information; there are gaps in my presentation and likely flaws in what I present. Further research is indicated, not only to illuminate the process of informed consent, but to address broader cultural processes of medicine as well.

I begin with a definition of informed consent. It will become clear that this definition itself is couched in concepts and language of traditional American understandings, values, and communicational habits. A concise, standard definition is broadened by anthropological considerations. Following the broadened definition, I spell out the cultural bases of this understanding more fully by examining what might be called "core American culture." I also explore informed consent as an element of an American sub-culture, that of its physicians. I then turn to several cultural minorities within American society, namely the Navajo, Hispanic Puerto Rican mainlanders, Vietnamese refugees, and Italian-Americans. I have selected these examples because they represent a range of differences to be found, and because the literature on them allows at least preliminary inferences. They were not chosen because of their numbers or because of their particular problems in the medical system of our society.

Informed Consent as Intercultural Communication. Lidz and Roth (1983) concisely summarize five elements of the "legal/ethical doctrine of informed consent" (for research as well as therapeutic interventions):

(1) The consent or refusal must be *voluntary;*

(2) the doctor or researcher must provide the patient or subject with all *information* relevant to the decision including risks, benefits, alternatives, and the nature and purpose of the procedure;

(3) the patient or research subject must be *competent;*

(4) the patient or research subject ought to *understand* what has been told to him, although this is probably not technically a legal requirement; and finally,

(5) that the *decision* should be made by the patient or research subject and that the doctor or researcher is obligated to respect that decision.

While these definitional elements may be necessary for effective informed consent, further elements underlie and accompany these. For example, the patient cannot be informed, nor can his or her understanding or decision be assessed without the informing physician's understanding of the patient's language, current beliefs, and communicational modes. There is therefore no informed consent without an extensive background exchange. The standard definition of informed consent is centered on the physician, ignoring elements of reciprocal exchange between patient and physician. Specification of these further elements shows effective and valid informed consent to be an event of reciprocal communication between parties with different understandings and communicational manners:

(a) Just as the patient must be competent, thus rational, and his/her decision voluntary, so must the physician be *competent, rational,* and his or her decision to recommend and/or provide the therapy also *voluntary.* The physician must be competent to have correctly assessed the patient's condition and to have rationally achieved a diagnosis for which a procedure is then recommended. He or she must be competent also in reasonable command of contemporary diagnostic and therapeutic knowledge. The physician must also make decisions voluntarily—free from external constraints or coercion to recommend a therapy other than in the patient's best interest, so long as this recommendation does not violate the physician's own social understandings or values. (Conflict here raises difficult issues for medical practice that cannot be further discussed here.) It is doubtful that informed consent is achieved if these precautions fail.

(b) The physician's competence must include *understanding* what is told to him or her by the patient, including symptoms, "history," and the patient's own conception of his or her problem and of what would count as relief or acceptable relief of it. He or she must be aware of the patient's habits of communication in order to understand the patient's expressions, and to assure as well the patient's comprehension of the information given. The physician must be *informed* about several aspects of the patient's cultural as well as his or her medical conditions. It is unlikely that the patient's informed consent can be effected without this information of and understanding by the physician.

(c) The patient's consent is not always a simple matter in our own society and may be more complex across social boundaries. The physician's understanding is required here also. From the patient's perspective, it may be that consent is completed only with subsequent acknowledgment by the physician.

(d) The alternative therapies formulated by the physician should include *non-intervention*. While this information may be implicit in risk-benefit statements of the proposed therapy, there is reason to believe this alternative may be understated and go unnoticed.

Cultural Sketches

Core American Culture

Understanding: Individualism pervades the understanding in American institutions, including medical ones. This deep principle bears directly on informed consent (Meisel *et al.* 1977). In medicine, the patient is regarded as the discrete locus of disease, the physician as the locus of healing powers (Manning and Fabrega 1973). Autonomy is both a goal and a means; persons, decisions, and actions may be autonomous to different degrees, along different dimensions (Miller 1981). Therapy is directed towards the restoration of wholeness in individual, autonomous, self-reliant persons who may then pursue their own objectives, as long as these do not interfere with similar "rights" of others.

Rosenblatt and Suchman (1964) claim that while white-collar workers regard the body as an instrument that can and should be kept finely tuned, blue-collar workers regard the body as a machine that wears down, with little repair possible. Although illness may allow temporary neglect of usual activities, the patient's dedication to cure and to resumption of social duties is assumed (Parsons 1951). Patients have most often been exculpated from their pathological conditions; increasingly both they and the natural and social (including the medical) environments have been implicated.

Choice is assumed to lie with individuated persons and to be appropriately fostered and protected there. True choices are made voluntarily, without constraint to choose other than in the chooser's best interest; a social orientation in these interests is not excluded from voluntary choice. Voluntarism assumes that located within persons are individuated wills that may and should be autonomously exercised. "He is his own person."

Knowledge is presumed to lie with the physician, based in that supreme epistemological standard, science. This control grows progressively with time. Science evaluates evidence by rational and pragmatic means, examining what works in empirical results, searching for efficiency, and computing results statistically in terms of risks and benefits.

Knowledge, especially the knowledge of science, is naturalized, that is, removed from cultural and social context; it is often regarded as value-free. It thus appears in a universal form as "information," allowing easy pouring into empty vessels.

Mind-body dualism is prevalent, despite and even alongside "holistic" currents of thought. "So, of all countries in the world, America is the one in which the precepts of Descartes are least studied and best followed. No one should be surprised at that." (De Tocqueville 1969: 429)

Values: Suffering is considered an undesirable evil, or one to be borne only temporarily (for example, the trauma of injections or more invasive operations) for consequent, more lasting comfort.

Action and control are valued above passivity (Williams 1970 Ch. 11). Specification of the consequences of inaction is thus only an implicit component of informed consent. It is unclear under what conditions a physician would request a patient to consent to non-intervention. The last stages of "terminal illness" may be an instance in which informed consent is offered for non-intervention. (This is reasonable since the illness is defined as "terminal" because no known intervention is helpful.) The principal goal of informed consent is the promotion of the patient's right to decide what should be done to him or her, thus the prevention of battery. The right to choose is a two-fold principle of autonomy: the patient may determine to be informed and to decide or not, and, if he or she chooses informed consent, may then choose among therapeutic courses. The individualistic, personal achievement and "self-realization" are highly valued.

Rationality and its manifestation in science is esteemed above other sources of knowledge (Williams *ibid.*); knowledge itself valued above ignorance and other forms of experience.

Rationality is demanded of both patient and healer in informed consent. There is a tension here between the highly valued and difficultly achieved knowledge of medicine and the egalitarian motive—an urge to distribute knowledge publicly and for individuals to direct their own courses on the basis of public knowledge.

Communication: "Truth," openness, and forthrightness are valued above harmony in communicational exchanges. Harmony may be regarded as a by-product of truth. In some "informal" settings, self-revelation may be regarded as a manifestation of honesty and self-awareness rather than of egocentricity. It may also be regarded as a way of self-improvement, through insight and expression.

While openness is valued, privacy and the right not to disclose are also highly valued. In medical settings this right may be threatened both insofar as disclosure may be deemed medically necesarry for patients and insofar as information disclosed may be used for other purposes. Psychiatric, sexual, and excretory disturbances are considered private matters and are often stigmatized. Patients may regard physicians' requests for certain kinds of information on these matters as highly intrusive and/or offensive.

There is a tension also between the egalitarian ideal by which people treat each other with mutual respect, and the high value placed on expertise, according to which the expert's dicta are regarded as beyond the capacity of their audience to evaluate. In medical encounters, patients are often complicit in denying their own capacity to know. Patients' incomprehension of physicians' "information" is notorious. Patients' personhood may be relatively devalued when they are addressed in familiar terms, while they address the expert physician, "Dr. . . . ."

Informed consent: Informed consent is preeminently a U.S. conception and an American value. Persons are analytically individuated, and (non-conflictual) individuality is cultivated. Rationality, forthright communication, and self-determination are highly valued. The doctrine of informed consent manifests, promotes, and protects these interests.

American Medical Sub-culture

Understanding: Especially since the nineteenth-century devotion to science in medicine and the concurrent development of the germ theory of disease, American medicine has followed an individualistic ontology of discrete "things" and inherent, determining properties. Spoken of as "entities" and "lesions" that lie within patients, they are thought to be caused, perhaps to be multiplied, by discernible internal and environmental agents. Therapeutic powers are held to reside primarily within physicians, secondarily in the patients to whom they administer, and again in environmental agents that may be introduced or withheld (Fabrega 1974: 248-253). Physicians are spoken of as "providers," patients as "consumers" to whom health care is "delivered."

Physicians commonly express the nature of their work as a combination of science and art (Elstein and Bordage 1979). Science may be regarded as the realm of the esteemed rationality, art as the realm of ambiguous intuition. (Science as understood by practising physicians differs from that as understood and/or practiced by research scientists and philosophers of science.) Science formulates principles of physiology, pathophysiology, and therapeutics, often in probabilistic terms. Probability may be regarded as inherent in causal events themselves rather than as a quality of knowledge (or science).

The art of medicine is thought to embrace an intuitive understanding of when and how to apply medical science to the particularities (thus also individualistic nature) of patients' diseases; "bedside manner" and the understanding of patients' states of mind and emotion and their social situations are also regarded as founded on a blend of intuitive art and common sense. This form of knowledge and its application are often subjugated, sometimes obliterated by the predominant science of medicine. The highly regarded Harrison's PRINCIPLES OF INTERNAL MEDICINE proclaims the essential "wedding" of art and science in medical practice, and then devotes 7 pages to questions of art and more than 2000 pages to the science of medicine in a clearly divorced manner.

The scientific foundations of medicine are regarded as value-free, and judgment is eschewed as airy and indecisive philosophy.

The understanding within medicine is characterized (Kleinman 1980) as one of "disease," contrasting with the "illness" understanding of patients. Disease is the medical conception of pathology as a universal biological process that may vary environmentally, but in which cultural conceptions and social determination play insignificant roles. Diseases and patients alike are thought to be "managed," as in productive enterprise. Illness, in contrast, is the patient's version of pathology, which the physician may reject entirely. Cartesian dualism is widespread, and disease-less illness may be said to be "all in the patient's head"; such patients may be dismissed as "crocks." The patient's report on his/her condition is filed in the standard physician's document under "subjective," the physician's own report under "objective." The contrast between disease and illness is useful in capturing a common dynamic tension between patient and healer. It is an essential justification for informed consent as a reconciliatory enterprise.

Physicians (general internists) I have studied refer to the object of their work as "physiological integrity." The human body is assumed to be separately knowable and treatable, and valuably so. The patient's psyche and social relations are regarded as peripheral; they are often avoided, even feared. Death (and similarly life) is defined not in terms of the person's loss of capacity for self-fulfillment, but in terms of brain-wave function. Euthanasia is repugnant to many physicians not simply because illegal.

Along with their scientific devotion and their compelling training and work, physicians give great weight to their own expertise and decisional rationality (Fox 1979). They may also recognize the ways in which patients' pathology interferes with their already lower states of knowledge and powers of reasoning.

Women, both as patients and as healers, have often been regarded as more vulnerable and less capable than men. Discrimination is extensive and may conform to beliefs about biological and psychological differences between the sexes (Marieskind 1980).

The practitioner's "science" may be mitigated by a strong pragmatism in which theory is of little relevance. What matters is what works. While most often not engaged in life-and-death problems, physicians are perpetually haunted by spectres of uncertainty, especially in tertiary care. Among medical colleagues, the distribution of "success" and "failure" is a vital social and epistemological process (Bosk 1979).

Values: Individualism takes another form in medicine. Physicians highly value not only an ability to effectively control patients' pathological conditions, but also the autonomy to decide how best to do so. The profession itself is expected to be largely self-regulating, its members likewise within the profession. Practitioners may justify their need for autonomy by the "art" of clinical judgment, the individuality or uniqueness of patients, the confidentiality of relations with patients, and the uncertainty and controversy surrounding much of medical practice.

The physicians' urges to autonomy, combined with their cultivated expertise, often yield a parental attitude towards patients. Given a universalistic conception of disease, physicians often think they know what is best for patients. Several attitudes prevalent among physicians converge on a strong devaluation and an avoidance or minimization of informed consent procedures (Lidz and Roth 1983, Kaufmann *el al.* 1981, Miller 1977). The provision of information and choice to patients is thought to be superfluous, wasteful, and often resulting in poor decisions. The patient's autonomy, as a goal of intervention itself, is not commonly valued, if recognized. Patients are thought not to want to know or to decide.

Health is a certain value, disease clearly not. Sickness is regarded as a hindrance rather than as a means to therapeutic powers (except, perhaps, among psychoanalysts).

Communication: Education in medicine includes not only theoretical and practical knowledge of pathophysiology and therapeutics, but a more subtle adoption of a language, a way of thought, and a form of behavior. Instruments, dress, manner, and diplomas on the wall are symbols of this distinction. Physicians speak among themselves in a dialect that patients do not understand. When they make efforts to translate, they often do so simplistically and/or disparagingly, believing that patients cannot usefully understand.

Communication with patients is commonly referred to as "bedside manner." Beyond the diagnostic elicitation of patient "history" and current symptomatology, and the prescription of therapy, bedside manner is often regarded as peripheral to patient "management." A physician I have studied refers to patient visits in which no medical information is exchanged as "just social." Talk with patients may serve at most to predict and to encourage "compliance."

It has been shown that in verbal exchanges with patients, physicians often dominate, effectively controlling both topics discussed and turn at speaking. Such domination is often mutually accepted.

Informed Consent: Positivist scientism, a passionate devotion to pure and passionless knowledge, has driven out several individualist strains of core American thought. While physicians vigorously protect their own autonomy, they often neglect that of patients, regarding patients' phenomenal and social worlds as peripheral to the etiology, course, and therapy of pathological conditions. Patient concerns are often regarded as a hindrance to "compliance" and good medicine.

Navajo (Great variation in belief may be found among the Navajos, perhaps corresponding to "education"—that is, in core American schools of thought—and to other forms of contact. Commonality may also be found with other indigenous groups [Hahn 1978].)

Understanding: According to Kunitz and Levy (1981), the Navajo live in a universe of complex causality involving human agents, their souls, and "supernatural" entities and forces. Diseases are thought to be caused principally by supernatural entities and forces that may be engaged by humans with morbid intent. A person's soul enters at birth and is firmly attached at the child's first laugh; it loosens in old age, and exits to an afterworld at death; it may be both the subject and the agent of disease. People may also bring on their own sickness through the breach of taboo; for example, incest leads to epilepsy-like "moth sickness." Thus, according to Kunitz and Levy (*ibid.* 357), volition may be involved not only on the part of witches or wizards, but of patients themselves.

"Navajo philosophy assumes that mental and physical phenomena are inseparable, and that thought and speech can have a powerful impact on the world of matter and energy" (Witherspoon 1977: 9).

"People are cured and blessed, vegetation is improved and increased, and health and happiness are restored by the power of thought" (*ibid.* 29).

Diagnosticians, like patients, are possessed by supernatural agents who reveal illness through several means. Ceremonial healers, most often not themselves diagnosticians, perform lengthy therapeutic "sand paintings." Healing is a profoundly religious affair (Adair and Deuschle 1970).

Navajo apparently do not regard their traditional medical beliefs as contradictory to biomedical beliefs. "White belief is good for whites, and Navajo belief is good for Navajos . . . attacking another person's beliefs (for example, in witches) is impolite and uncouth" (Kunitz and Levy, *op. cit.*: 360). White medicine is generally thought to treat symptoms, while Navajo medicine treats causes. Physicians are spoken of as "bearers of medicine," and are not given the same status as ceremonialists who are concerned with cosmic forces.

Values: "Disease" itself may be an ambivalent state, since, while disrupting normal roles, it may also be a step towards a healing role.

Navajo value harmony in their social relations, and indeed, disease itself may be a sign of disharmony in social or other cosmological relations. Navajo seem to hold tolerance and respect for others in high regard. They seek to strengthen relations of interdependence within the order of the universe, rather than promoting independence.

"Navajo believe that each person has the right to speak for oneself and to act as one pleases" (Witherspoon 1977). This individualism, Witherspoon notes, is complemented by an emphasis on communalism. Ideal behavior is peaceful, cooperative, and unselfish.

Communication: The Navajo diagnostician knows not by asking detailed questions of patients, but through transient possession by cosmic powers; he may not inform the patient of much more than a diagnostic finding and recommended ceremonial therapy. Informed consent is not a Navajo tradition. Detailed knowledge of symptoms is not regarded as necessary for diagnosis. Navajo patients consider the intensive questioning (and examination) by physicians both intrusive and indicative of the physicians' lack of powers. Not only are physicians' "remedies" symptomatic; these healers seem also to require excessive "knowledge" in order to decide what to do.

Still, according to Kunitz and Levy, Navajo want to know what their physicians think. Perhaps ethnocentrically, these authors (318) note that Navajo "appreciate being treated as adults who can make mature decisions when in posesssion of the pertinent facts." They want to be informed, moreover, in a manner that treats their beliefs not as superstitious, but as alternatives or even complements worthy of respect. They "complain bitterly" about the distance of medical facilities, the time spent waiting, and the brief contact with physicians, with poor translation and little respect.

Speech is a religious act according to Navajo thought (and to Old Testament thought, now distant) (Witherspoon 1977). One may speak, therefore, not only to inform about things, but to affect them, thus also to heal. "Ritual language does not describe how things are; it determines how they will be" (Witherspoon 1977: 34). "A request made four times cannot be easily denied" (Witherspoon *ibid*: 22).

Informed Consent: While Navajo are not traditionally accustomed to informed consent, in their encounter with Western medicine they often desire information about physicians' diagnoses, recommendations, and alternatives. They wish to be informed in a respectful and gentle manner and in an idiom that makes sense in terms of their own understanding. Such knowledge and its communication are regarded as an essential causal element of healing itself.

Italian Americans (Ragucci [1981] emphasizes great variation among Italian Americans, according to, for example, recency of immigration, age, and generation. There are also noticeable similarities between immigrant and national Italians, and between Italian Americans and other Indo-Europeans as well.)

Understanding: Ragucci (1981) reports that Italian American theories of disease and healing embrace natural, "supernatural," and human agents or causes. Human agents may be aware of and deliberate in their participation, but need not be. Especially older and recent immigrants, and even those of the following two generations, believe in spiritual causation; for example, in *malocchio* ("evil eye"), *castiga* (curses, both human and Godly), and in healing by the intervention of God or the saints.

The Italian American description of the patient's position as one of *soggezione* (that is, subjection, uneasiness, and embarrassment) rather than obligation, suggests a passive conception of sickness—patience and affliction from which release is desired.

Italian Americans also maintain theories of inheritance and contagion that are composed of traditional concepts, such as "blood" and "wind," as well as notions from biomedicine.

Immigrants from rural areas often show greater knowledge of physiology than do urban-born Italians, perhaps from their butchery of animals. Much biomedical information originates with physicians and spreads through the Italian American community. In both therapy and prevention, diet and appropriate behavior are regarded as essential. In prescribed therapies, putative "equivalents" may be substituted for the specific therapies prescribed; for example, foods that do not taste salty may be substituted for prescribed low-sodium diets.

Symptoms are commonly recognized and responded to when and insofar as they restrict normal and desired activity. Emotion and environment are regarded as important predisposing factors and discussion of these is thus expected in therapeutic settings. Expression of emotion is regarded as itself therapeutic.

Values: Moderation is regarded as a virtue and as indicative of protection of one's own health and that of others. Family solidarity is emphasized and is important in medical events.

Vergogna (modesty or shame) is also a virtue, especially for women.

Ragucci (1981) notes not only frugality and dread of "going on welfare" (241), but also difficulties in relinquishing the sick role when supported by welfare (243). Ambivalence about role fulfillment or "work" is suggested.

Communication: Italian Americans commonly express medical problems in a full narrative form that includes not only medical "symptoms," but also personal reactions and familial and social concomitants. Zola (1973) has claimed that Italians often report more symptoms than do other ethnic groups; in consequence they may be diagnosed as having psychiatric problems. They expect their narratives to be heard and dealt with. Curt interactions with physicians are regarded as insufficient. House calls may be expected.

A Sicilian remarks (NEW YORK TIMES, Dec. 31, 1981: C16), "Your mouth means nothing without your hands."

Menstruation and other urogenital problems are expressed only with great difficulty, especially to opposite-sex physicians. Discussion may be facilitated by chaperones, by euphemism, and by conventional apology.

Older Italian Americans and recent immigrants especially prefer not only Italian-speaking physicians, but those from the same provenance.

Informed Consent: Italian Americans expect extensive explanation of physician diagnosis and recommendations. Communication should be respectful, and especially careful with regard to "shameful" issues. While patients themselves and their close relations are thought to participate in both pathogenesis and healing, it is not clear how "choice" is considered or valued.

Vietnamese (One may find both great variation among persons and among social groups within Vietnam, and much commonality between Vietnamese cultures and the cultures of other, historically connected Southeast or East Asian societies.)

Understanding: Nguyen Dang Liem and Kehmeier (ms., n.d.) portray the Vietnamese as inhabiting a universe whose present conditions are vastly overshadowed by the past. This is a universe shaped by the confluence of Buddhist, Confucian, Taoist, and even Christian principles. One's present state is appropriate to one's actions in previous incarnations. Hickey (1964: 117) claims that village Vietnamese believe in predisposition as well as predestination; that is, in both immediate cause and ultimate sources in universal disharmony and disease. According to the strong and pervasive Buddhist strain in Vietnamese thought, present "life is a vast sea of suffering in which man wallows hopelessly" (Nguyen Dang Liem and Kehmeier). "The more we suffer, intelligently, the deeper our life. Buddha said that life is suffering, and taught us how to avoid both. This is wrong. Deep suffering is deep life." (R. H. Blyth, reviewed in *New York Times Book Review*, Feb.14, 1982: 18)

Although one may seek to mitigate suffering through proper living, the major effects of one's present good works may occur only in future incarnations. The merit acquired by virtuous behavior accumulates in better health, greater happiness, elevated social and concomitant political, economic, and spiritual status in society in future lives. Hierarchy and status are signs of goodness rather than evil or corruption. Therefore Vietnamese patients are likely to accept whatever the respected physician says as appropriate to that situation. Further release from suffering is thought to follow the renunciation of desire and resistance. Thus, relief from the suffering of disease may not be pursued relentlessly among Vietnamese. Taoist thought, which finds ultimate reality in the way of nature, and man's proper place in passive and harmonious relationship with the universe, is especially non-interventionist.

Etiology and therapy may be thought of in cosmological senses not to be located within or around the patient and healer, but in vast forces spanning time. Likewise, personal cure may be of minor significance to the course of the sufferer's consequent regenerations. It is not that Vietnamese enjoy suffering, but that their suffering is interpreted in cosmic rather than in local and individualistic ways.

Confucian thought gives high value to learning for the cultivation of one's self in society. Learning is primarily directed toward social harmony, and not to one's own condition. In the healing process the healer is only an instrument of cosmic forces; knowledge, especially on the part of patients, may be regarded as irrelevant, if not presumptuous.

Nevertheless, some explanation may allay fears; for example, that blood drawn for laboratory analysis will be permanently lost.

Hickey (1964: 57) claims that core traditional beliefs such as these persist in both urban and Christian Vietnamese.

Values: In the pursuit of future release from suffering, desire and achievement, or will, are renounced. The cultivation of will and autonomy are regarded as selfish and as sources of future, if not present, suffering. One seeks rather one's proper place in the social cosmos; one pursues meritorious behavior in obedience to authority, in prudence, and in harmonious relations with present as well as past consociates.

Falsehood carries no moral stricture (Nguyen Dang Liem and Kehmeier). In Buddhism, rationality—and certainly science—are not preeminent forms of knowledge: Ordinary consciousness itself may be regarded as a hindrance rather than a basis of knowledge (Zimmerman 1951).

Not without reason, Vietnamese hold foreigners or outsiders in suspicion. While within one's village, one has a place in the legal, moral, and spiritual universe; beyond the village one's place is indeterminate. Thus "hospitalization is anathema to most villagers" (Hickey 1964: 120).

Communication: In talk with others, status differences—part of the larger social order—are of preeminent importance. Harmony in these relations is of far greater value than "truth" and the exchange of information; one speaks primarily to promote interpersonal harmony.

The Vietnamese word "Da" means "Yes," but more often connotes "I am politely listening to you" than "I agree with you." Politeness usually prevents contradiction or even questioning, and may be manifested instead in a smile, which masks embarrassment over the dilemma. Straightforwardness is regarded as crude and wrong.

In speech, one averts one's gaze from the other; legs are kept uncrossed, feet on the ground; gesticulation is avoided. Self and "feelings" are not subjects of talk, and may be discussed only indirectly. Women defer to men, children to parents, and subjects to authorities who may include employers and physicians.

Informed Consent: The individualism central to the doctrine of informed consent is absent in the traditions of Vietnamese thought. Self is not cultivated, but subjugated to cosmic orders. Information, direct communication, and decision may be regarded as arrogant. Although informed consent may thus be neither understood nor valued, Vietnamese interests and concerns should still be pursued in medical encounters.

Mainland Puerto Rican Hispanics (Variation may be expected within Puerto Rican populations alongside commonalities with Island Puerto Ricans, Mexican Americans, and Iberians.)

Understanding: Puerto Ricans believe that persons are comprised of finite physical and eternal spiritual parts, and that sickness may be caused by different interrelations between these parts and other disembodied spirits. In both etiological and therapeutic understanding, Puerto Ricans may combine beliefs from biomedicine with others; for example, the Spiritist Cult. Harwood (1981) describes these two perspectives as significantly complementary and not as competitive. He highlights the role of physicians as primary sources of biomedical knowledge in the Puerto Rican community.

Harwood describes Puerto Rican medical thought as "psychosomatic" in that mind (or spirit) and body are regarded as interacting in the production of disease and healing; this medicine is also "social" in that family and social network are held to be crucial elements in both the causation and the cure of disease. Successful healers, whether physicians or spiritists, are believed to be important participants in the spiritual and social event of healing. Spiritists are highly regarded in their ministry of spiritual and social disturbance. They are thought to heal in their capacities as media for spirits who speak through them.

Prominent in Puerto Rican etiological theory is the widely found principle of "hot" - "cold" balance (the thermal reference here is only partial). Harwood argues that the prescriptions of this theory are also compatible with and should be made use of by biomedical practitioners. People are regarded as capable of participation in the causation (as well as the relief) of their own suffering and that of others. It is not clear (to me) what role "will" and "choice" play in these interventions, or how they are valued.

Values: Sickness and its relief are ambivalent events in that the patient's suffering may induce healing powers. A healer achieves therapeutic powers by being healed.

Respeto, respect for the dignity of others, is a strong value in interaction.

Communication: Harwood claims that Puerto Ricans have a strong desire for information and for information given without condescension. Puerto Ricans combine esteem for biomedical expertise with strong conviction in their traditional diagnostics. They expect these diagnostics to be understood and taken into account, or at least responded to.

The exchange of information is important not only for diagnosis and to allow therapeutic options. Puerto Ricans regard the understanding and adjustment of personal and interpersonal difficulties as inseparable from therapy. Patients, along with their families, expect to be engaged in the medical encounter, and medical prescriptions are not likely to be heeded without such involvement. Confidentiality is also expected, especially with regard to specific medical problems; e.g., venereal disease, *locura* (madness), and urogenital symptoms.

Puerto Ricans prefer warmth and continuity in their relations. Communication in Spanish may be a charged issue; among bilinguals, some prefer speaking in Spanish as a symbol of recognition, while others reject talk in Spanish as an admission of their own inability in English. Puerto Ricans are said to like eye contact (though intense eye contact with children is thought to cause the potent disease, *mal ojo* [evil eye]). Many Puerto Ricans defer to authority and may appear not to understand, yet not ask, questions; they may seem to "consent," but then to fail to "comply." Intergender principles of modesty may hinder therapeutic relations.

Informed Consent: Mainland Puerto Rican Hispanics desire information in terms that are comprehensible by their own conceptualization. Such communicational exchange is regarded as a vital element of healing itself. The conception and valuation of "choice" among therapeutic alternatives is unclear.

Cultural Variation of Understanding, Value and Communication in Informed Consent. These sketches of several cultural groups within the United States indicate some of the variations that may be found in understanding, values, and communicational patterns affecting informed consent. More variation may be expected as other groups are considered, or as the groups reviewed above are known to greater depth. Again, it should be noted that the sketches describe norms to which societal members conform (and from which they deviate) in varying degrees.

In this brief excursion, a striking contrast emerges: While etiology and therapy are very differently conceived in different cultural settings, a desire for informational disclosure, therapeutic choice (with possible exception of the Vietnamese), and respectful communicational exchange are common in all groups except that of the profession of medicine itself. Numerous forces in the formation and conduct of medical work in our society converge to foster a belief and corresponding practice in which disclosure and patient decision are regarded as superfluous if not obstructive.

In many non-Western cultures, disease and healing are regarded as parts of a total cosmic scheme of things that embraces not only the disturbance and restoration of bodily function, but, in addition, of mind and spirit, relations among humans and between humans and vaster forces, and the fundamental principles of morality. The manifold individualism of traditional American thought and its medical version are absent in these foreign traditions. In medicine especially, what for other people are cosmic elements have here been distinctly separated into entities. Medicine has tended to focus on the material, on quantification, and on rationality, denigrating and avoiding the mental, the qualitative, and the irrational. While in many non-Western societies, the events of individuals are public and participatory family and community affairs, for American physicians these events more often involve applications of exclusive expertise to highly circumscribed problems. While for the former, reciprocal communication is a part of healing, for the latter it is at best tangential.

The doctrine of informed consent is an outgrowth of fundamental American values of autonomy, rationality, efficiency, and health. The work of medicine bends fundamental values to the extent that informed consent is regarded as a hindrance, if not a threat to the practitioner.

Recommendations: Enhanced Therapeutic Communication

Medical institutions in American society may be reformed in several directions to enhance intercultural communication and concurrent possibilities of appropriately informed, valid consent. Such changes are relevant not only for medicine administered to the members of cultural minorities, but to all patients, including even physicians themselves as patients. There is good evidence to support the beliefs of many "traditional" medical systems that communication is not a peripheral, but a central facet of healing, and that communicational failures may be iatrogenic. More specific recommendations follow.

Procedures for informed consent can be effective only when carried out within more comprehensive relations of mutual communication. Documents of informed consent may then attest this more extensive exchange. The achievement of communicational exchange may be analyzed into smaller steps that must include elicitation by the physician of the patient's cultural attitudes regarding his or her condition and an understanding of his or her communicational modes. Only following such steps can the right to informed consent be appropriately offered. If accepted, medical information may be given, the patient's understanding assured, and his or her decision elicited and followed. Compliance would then become a mutual, reciprocal facet of the healing relation.

By core American cultural standards, both physician and patient should be patient advocates, striving to achieve the patient's autonomy, and by autonomous means thus maximizing choice (limited principally by conflict with the similar autonomies of others). The proposals that follow are intended to enhance the achievement of these standards by focusing on different participants and organizational aspects of medicine in our society.

Patient advocates might act as "culture brokers" (Weidman 1978) to facilitate or monitor the mutual translation of knowledge between patient and physician. Such an ambassadorial role would demand great skill and sensitivity. More appropriate to larger medical facilities, such culture brokers might be trained in the general understanding of patient viewpoints and desires, and in their negotiation with medical personnel. In regions where particular cultural groups are found in large numbers, brokers might specialize in the problems of these groups. Banks of translators have been used in some institutions, and such persons should be alerted to the medical conceptions of the groups for whom they work and to their particular difficulties in medical settings. For the smaller and private practices within communities, centralized panels of culture brokers might be made available, either from within larger institutions or separately.

At least since the Flexner reforms of 1910, medical education has included understandings, values, and communicational practices opposed to mutual understanding between patient and physician. Further reform of physician education is thus central to the promotion of informed consent procedures, the requisite understanding, and the likely consequences of better outcomes in health and satisfaction. Strong resistance to such change should be expected.

Reform might take two complementary courses. One is the understanding of the relevance of patients' cultural contexts in the causation of disease, in processes of therapy, and in the formation of understandings, values, and ways of communication that guide the response and conduct of patients and others in health and illness. There has recently been a move in this direction in the teaching of the disease/illness contrast and of the procedures for negotiation between patient and physician (Katon and Kleinman 1981). The reform required is extensive, since behavioral science can no longer be regarded as peripheral, but as a basic and indispensable discipline of medical practice.

Perhaps more difficult, medical education must encourage physicians' treatment of themselves as cultural beings whose work profoundly affects and is affected by their own "selves." Self and the culture that shapes it significantly determine the character of the healing relation, including its most technical facets. Yet such reflectivity has been discouraged in medical education, with rare exception in psychiatry and family medicine.

Self analysis has been promoted in "Balint seminars" (see Balint 1964) in which practicing physicians discuss the personal problems of their work and the relations of these problems to patients' therapy; but these seminars have not been long-term, ongoing, or widely used. I believe that such seminars should be central elements of the entire course of medical training, from undergraduate through residency and even into practice.

Physicians' awareness of the cultural roots of patient and self and of the essential involvement of culture in pathological and therapeutic events would lead physicians to promote rather than to subvert informed consent.

Public education on the possibilities and limits of medicine would inform patients about what to expect in their encounters with medical institutions. It might reduce (but alternately might increase) fears; it would make expectations more realistic and enhance patient use of medical resources. It might quell the epidemic of malpractice suits. It would better inform patients on what to expect in medical settings, how to usefully pursue "information" and make "decisions."

Public education might take place in the public and private school system (with provision of curricula, audio-visual, and textual material), through television and radio, and within medical settings in the form of written material or films.

With great success, vast resources have been expanded in the research on the physiological aspects of disease. Relatively few resources have been directed to the social and psychological facets of medicine. Much research is needed in these areas. With regard to the theme of this essay, it bears repeating that our knowledge of the medical aspects of cultural groups in our own society is at best introductory. Our knowledge of the basic conceptions and values of minority patients is rudimentary, and the consequences of this ignorance perhaps underestimated and neglected. Our ignorance is not only of cultural minorities. I do not believe we have good knowledge of the understanding of disease, health, and medical practices of middle- and lower-class Americans who are the vast majority of patients. Further research and information is needed on the cultural sources of physicians as well as of patients, and on the pathological and therapeutic consequences of interactions between these.

A medicine that treats patients while neglecting the cultural basis of their pathology—their etiological and therapeutic understandings, values, and practices—will at best be a medicine of bodies. Persons will be battered. Informed consent may be little understood or valued by different cultural groups. Yet its acceptance or waiver may signal a communicational interchange of valuable information between patient and healer, in which mutual understanding has at least been pursued. The event of informed consent may thus serve as an index of a fuller and more personal medicine.

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G

Autonomy And Informed Consent

Gerald Dworkin, Ph.D.*

> "Why do you assume you have the right to decide for someone else? Don't you agree it's a terrifying right, one that rarely leads to good? You should be careful. No one's entitled to it, not even doctors."
>
> "But doctors *are* entitled to the right—doctors above all," exclaimed Dontsova with deep conviction. By now she was really angry. "Without that right there'd be no such thing as medicine!"
>
> Solzhenitsyn, Cancer Ward

> The slave doctor prescribes what mere experience suggests—and when he has given his orders, like a tyrant, he rushes off. But the other doctor, who is a freeman, attends and practices upon freemen—he enters into a discourse with the patient and with his friends—and he will not prescribe for him until he has first convinced him; at last, when he has brought the patient more and more under his persuasive influences and set him on the road to health, he attempts to effect a cure.
>
> Plato, The Laws

In ethics, as in the law, there is often agreement concerning what to do in a particular case, or about the importance of a moral principle, co-existing with disagreement about why we should act in a certain manner, or on the nature or basis of the moral principle. Similarly, moral theories may agree about specific cases of lying while giving different accounts of why a lie is or is not justified. Becoming clearer about the sources of our principles or judgments is of both practical and theoretical importance. For agreement in particular judgments may conceal the possibility of disagreement in cases not yet encountered. Understanding the deeper sources of our judgments allows us to anticipate such divergences between ourselves and others. At the theoretical level, understanding the bases of our principles and judgments provides one mode of testing our moral theories. For the task of a theory is not to match our judgments but to account for those that are sound and criticize those that are faulty. A good theory unifies and explains its data and generates new judgments that are tested against our moral experience.

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In this essay I shall consider the doctrine of informed consent, as it appears in the context of health care, and the various concepts that have been put forward as a basis for it. In particular I shall focus on the concept of autonomy, attempting to clarify its nature, distinguish it from other concepts, and defend its claim to be at the center of the justificatory basis for informed consent.

Justifications for Informed Consent

It is clear from examination of the legal and philosophical literature on informed consent that its defense has involved appeals to very different kinds of considerations. I give here a sample of typical assertions of such claims. Many of them come from the legal, rather than philosophical, literature. This is natural since the doctrine is a creature of law. But my interest in the doctrine is as a moral not a legal view. I make this distinction, not because moral and legal contexts are sharply separated, but to remind the reader that the law has specific features (such as the need to make a decision) that do not allow one to argue directly from a legal justification to more general normative conclusions.

> In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal . . . And to safeguard the patient's interest in achieving his own determination on treatment, the law must itself set the standard for adequate disclosure.[1]
>
> The constitutional right of privacy includes the right of a mature competent adult to refuse to accept medical recommendations that may prolong one's life and which, to a third person at least, appear to be in his best interests.[2]
>
> Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be

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[1] Canterbury v. Spence, 464 F.2d (D.C. Cir.) at 786.

[2] *In re* Yetter, 62 Pa. D&C 2d 619 at 623.

> of sound mind, expressly prohibit the performance of lifesaving surgery.[3]

> The requirement of informed consent has two parts, both of which must be met before a medical intervention is permissible: first, that sufficient information be disclosed to the patient so that he can arrive at an intelligent opinion, and second, that the patient agrees to the intervention being performed. The latter facet in particular reflects the concern, traditional in western societies, that the autonomy of the person be respected . . . autonomy is centrally associated with the notion of individual responsibility. The freedom to make decisions for oneself carries with it the obligation to answer for the consequences of those decisions.[4]

> The purpose of requiring the patient's consent to treatment is to protect his physical and psychic integrity against unwanted invasions, and to permit the patient to act as an autonomous, self-determining being.[5]

> The very foundation of the doctrine (of informed consent) is every man's right to forego treatment or even cure if it entails what for him are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortion falls short of what the law regards as incompetency. Individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish ones.[6]

> The principle of an informed consent is a statement of the fidelity between the man who performs medical procedures and the man on whom they are performed . . . The principle of an informed consent is the canon of loyalty joining men together in medical practice and investigation.[7]

> . . . there does seem to exist a positive right of informed consent which exists both in therapeutic and experimental settings . . . From whence derives this right? It arises

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[3] Nathanson v. Kline, 186 Kan. 393 at 406.

[4] A. M. Capron, *Informed Consent in Catastrophic Disease Research & Treatment*, University of Pennsylvania Law Review 123 (December, 1974), p. 365.

[5] A. Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decision-making*, Wisconsin Law Review, Vol. 1979, no. 2, p. 420.

[6] F. Harper and F. James, The Law of Torts, supp. 68, p. 61.

[7] P. Ramsey, The Patient as Person (Yale University Press, 1970), p. 5.

> from the right each of us possesses to be treated as a person.[8]
>
> Although the requirement of informed consent is not traditional in Hippocratic medicine, it is possible to justify such a requirement on patient-benefitting grounds. Indeed, if we recognize that judgments about what is beneficial to a particular patient will vary from patient to patient depending upon the particular norms and values of that person, a strong case can be made that informing patients of treatment alternatives so that they can participate in or even control the decision-making process will increase the likelihood that patient-benefits will be maximized.[9]

I have not listed a class of justifications that also appears in the literature. In these an appeal is made to the good consequences for others that would follow from adhering to the doctrine of informed consent. This functional analysis, exemplified by the work of Jay Katz, relies on the encouragement of rational decisionmaking, the protection of the experimental process, increasing society's awareness of the research process, and so forth. I am not denying that such reasons can play a part in the justification of informed consent but I wish to focus on defenses that refer to some property of the individual whose consent is being sought, because I believe, but will not argue here, these operate at a more fundamental level than the appeal to more general consequences.

Autonomy, Privacy, and Liberty: Distinctions

Our brief survey shows that informed consent is justified in terms of privacy, self-determination, loyalty, autonomy, freedom, integrity, dignity, and benefits. Individuals have the right to be treated as persons, as masters of their own body, as responsible for their decisions, as makers of choices. Though frequently these are regarded as equivalent notions it should be fairly obvious that they are quite different values.

Privacy and Autonomy. To take the most glaring case, consider the values of privacy and autonomy. Privacy consists of the ability of an individual to maintain control of the information about himself that is available to others. It is intimately linked with the idea of being scrutinized by others, although, with the invention of various devices for intercepting communications, it extends to what we say, think, or do. Thus, typical interferences with privacy include observations of our bodies, behavior, and interactions with others. The more control we have over knowledge about ourselves, the more privacy we maintain.

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[8] B. Freeman, *A Moral Theory of Consent*, Hastings Center Report (August, 1975), p. 32.

[9] R. Veatch, *Three Theories of Informed Consent: Philosophical Foundations and Policy Implications*, The Belmont Report (DHEW Publication No. (OS) 78-0014), pp. 26-28.

Without going into the analysis of autonomy I shall present below it is clear that while privacy may be related to autonomy in a number of ways it is not identical with it. The relationship between the two concepts may be empirical; i.e., it may be claimed that a condition for the development of our autonomy includes considerable respect for our privacy. The relationship may be conceptual; i.e., it may be argued that to deny people privacy is to deny them the respect for personhood that is closely linked with their autonomy.

But a few examples should show that the concepts are distinct. One way of interfering with your autonomy is to deceive you. This interference with information is, however, just the opposite kind from that involved in interference with privacy. What is controlled is the information coming to you, not the information coming from you. I do not know something about you that you might wish to conceal. I conceal something from you that you might wish to know. Thus, autonomy but not privacy is diminished.

Similarly, privacy may be interfered with but not autonomy. If someone taps your phone conversations without your knowledge he interferes with your privacy. But your decisions, your actions, your values, are in no way changed or altered from what they might be otherwise. You are as self-determining as ever.

The intellectual disorder that arises from confusing these two notions may be observed in the Supreme Court decision in Griswold v. Connecticut that ruled that prohibition of the use of contraceptives was a violation of the constitutional right of privacy. Whatever the misdeeds of the state of Connecticut in this matter it did not involve any attempt to get acquainted with the personal lives of its citizens. It did involve attempting to interfere with the procreative decisions of citizens, and hence raised issues of autonomy and liberty—but these are quite different issues. One reason for the confusion of these concepts is that violations of autonomy and of privacy exhibit a common failure to respect another person as an independent moral agent. But they do so in different ways and ought not to be assimilated. In particular the doctrine of informed consent cannot rest on a notion of privacy. For it is the information flow to the patient that is at issue, not the patient's control over information about himself.

Liberty and Autonomy. While the distinction between autonomy and privacy is clear the identification of liberty and autonomy is much more plausible and tempting. In this section I will argue that the two notions ought to be distinguished and the concept that most effectively grounds the doctrine of informed consent is autonomy.

I suggest we think of liberty (or freedom, which I use as a synonym) as the ability of a person to do what he wishes and to have significant options that are not closed or made less eligible by the actions of other agents or the workings of social institutions. Historically there have been two influential traditions that have explicated the idea of liberty in contrasting terms. On one view, associated with the names of Hobbes and Mill, liberty is the absence of interference with a person's actions. Coercion and force are the main enemies of liberty. Another tradition, that of Rousseau and T. H. Green, understands liberty as being more than simply the absence of interference, as including the presence of a range of alternatives and opportunities. But whether the emphasis is on restrictions or opportunities the core notion of liberty is the ability of a person to effectuate his decisions in action.

If, for example, a doctor forces a Jehovah's Witness to have a blood transfusion against his will, this is a direct interference with the liberty of the patient. But since this is also clearly a denial of the patient's autonomy, understood as a power of self-determination, the thought arises that autonomy and liberty are the same.

An example from Locke shows us that they are not. Consider a person who is put into a prison cell and told that all the doors are locked. The guards go through the motions of locking the doors but in fact one of the locks is defective and the prisoner could simply open the door and leave the cell. Because he is not aware of this he, quite reasonably, remains in his cell. The prisoner is, in fact, free to leave the cell. His liberty has not, although he does not know this, been limited. His autonomy has been limited. His view of the alternatives open to him has been manipulated by the guards in such a fashion that he will not choose to leave. This example shows that self-determination can be limited without limiting liberty.

It might be suggested that although we can interfere with autonomy but not liberty, the converse does not hold; that all interference with liberty is necessarily interference with autonomy. For if we prevent a person from doing what he wishes, do we not interfere with the ability of a person to choose what he shall do, to fashion his life? Although this seems plausible I believe it is false. We accept the claim because we are used to focusing on cases where a person wishes to be free from interference, resents having his liberty taken away. Consider, however, the classical case of Odysseus.

Not wanting to be lured onto the rocks by the siren, Odysseus commands his men to tie him to the mast and refuse all later orders he might give to be set free. He wants to have his liberty limited so that he and his men will survive. While his behavior at the time he hears the sirens is not free—he struggles against his bonds and orders his men to free him—there is another aspect of his conduct that must be understood if we are to evaluate his situation correctly. He has a preference about his preferences, a desire not to act upon certain desires. He views the desire to steer his ship towards the sirens, and the rocks, as an alien desire. In limiting his liberty in accordance with his wishes we promote, not hinder, his efforts to define the contours of his life. We promote his autonomy by denying him liberty.

Liberty is a concept that applies to the desires and preferences a person has for particular states of affairs. It focuses on what a person wants to do at the level of action. But this level ignores a crucial feature of persons—their capacity to reflect upon and adopt attitudes towards their desires, wishes, and values. It also ignores the ways that their desires and preferences were acquired. If it matters to persons not only what they value and believe but also the process by which they came to these states then only a fuller appreciation of their higher-order preferences will illuminate self-determination.

If one looks at the structure of the arguments for and against informed consent one has a better explanation of that structure by assuming that autonomy, not liberty, is the central value in the doctor-patient relationship. If we consider the main argument for denying the necessity of informed consent, that of therapeutic privilege, we see that this is a paternalistic argument. It is grounded on the idea that we ought to advance the patient's welfare even if this involves denying him the knowledge needed to make consent informed.

Attempts to define the concept of paternalism in the medical context view paternalism as the denial of liberty. One philosopher characterizes paternalism as "interference with a person's freedom of action or freedom of information, or the deliberate dissemination of misinformation."[10]

This definition implies that if a doctor does not misinform or fail to reveal information to a patient but tells the patient more than he wants to know the doctor does not act in a paternalistic fashion. But when a doctor insists upon telling a patient what he does not want to know, for his own good, this is a clear case of paternalism.

Or to consider a different kind of case, a husband might hide his sleeping pills fearing his wife's suicidal tendencies; again an act of paternalism, but not one that interferes with either freedom or the flow of information.

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[10] A. Buchanan, *Medical Paternalism*, PHILOSOPHY AND PUBLIC AFFAIRS 7, no. 4 (Summer, 1978), p. 372.

Only if one views paternalism as the denial of autonomy, as the substitution of one person's judgment for another, do these cases become paternalistic. The doctor who tells the patient more than he wants to know and the husband who hides the pills both substitute their judgment for another person's. There is a usurpation of decisionmaking. I am not, at this point, arguing this is right or wrong. I am only claiming that if autonomy is the value against which paternalism offends we have an explanation of why certain acts are paternalistic—an explanation that is lacking in the view that it is liberty that is at stake.

Autonomy is a richer notion than liberty, which is conceived either as mere absence of interference or as the presence of alternatives. It is tied up with the idea of being a subject, of being more than a passive spectator of one's desires and feelings. Some of the flavor of this idea is presented by Isaiah Berlin.

> I wish my life and decision to depend on myself, not on external forces of whatever kind. I wish to be the instrument of my own, not of other men's acts of will. I wish to be a subject, not an object; to be moved by reasons, by conscious purposes, which are my own, not by causes which affect me, as it were, from outside. I wish to be somebody, not anybody; a doer—deciding not being decided for, self-directed and not acted upon by external nature or by other men . . . I wish, above all, to be conscious of myself as a thinking, willing, active being, bearing responsibility for his choices and able to explain them by reference to his own ideas and purposes.[11]

It is this notion that I want to develop more carefully and that provides the soundest basis for explaining and justifying the doctrine of informed consent.

The Concept of Autonomy. The central idea that underlies the concept of autonomy is indicated by the etomology of the term: *autos* (self) and *nomos* (rule or law). The term was first applied to the Greek city state. A city had *autonomia* when its citizens made their own laws, as opposed to being under the control of some conquering power. There is then a natural extension to persons as being autonomous when their decisions and actions are their own.

It is characteristic of persons, and seems to be a distinctively human ability, that they are able to reflect upon and adopt attitudes towards their desires, intentions, life plans. One may not just desire to smoke but also desire that one not have that desire. One may be motivated by jealousy and anger and also desire that one's motivations be different.

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[11] I. Berlin, TWO CONCEPTS OF LIBERTY (Oxford: Clarendon Press, 1969), p. 123.

A person may identify with the influences that motivate him, view himself as the kind of person who wishes to be moved in particular ways. Or he may resent being motivated in certain ways, be alienated from those influences, prefer to be the kind of person who has different values and preferences. I am defining autonomy as the capacity to reflect upon one's motivational structure and to make changes in that structure. Thus, autonomy is not simply a reflective capacity but includes some ability to alter one's preferences and to make them effective in action. Indeed to make them effective partly because one has reflected upon them and adopted them as one's own.

Autonomy is a second-order capacity to reflect critically upon one's first-order preferences and desires, and the ability to either identify with these or to change them in light of higher-order preferences and values. By exercising such a capacity we define our nature, give meaning and coherence to our lives, and take responsibility for the kind of person we are.

Liberty, power, and privacy are not equivalent to autonomy but they may be necessary conditions for individuals to develop their own aims and interests, and to make their values effective in the living of their lives.

It is an implication of my view that there is no specific content to the decisions an autonomous person takes. Someone who wishes to be the kind of person who does whatever the doctor orders is as autonomous as the person who wants to evaluate those orders for himself. This view differs from others in the literature. Wolff, for example, says (in the context of the citizen and the state) "[t]he autonomous man . . . may do what another tells him, but not because he has been told to do it . . . By accepting as final the commands of the others he forfeits his autonomy."[12] But this conception of autonomy not only has the consequence that no government is legitimate but also that such values as loyalty, objectivity, commitment, and love are inconsistent with being autonomous.

Although I do not believe there is a direct logical link between acting autonomously and being critical and independent in judging and acting, it is plausible to suppose there are psychological connections. It is likely that those who practice in their life a critical reflection on their values will tend to be suspicious of modes of thought that rely on the uncritical acceptance of authority, tradition, and custom.

It should also not be thought that those who autonomously choose to follow the commands of others can thereby escape responsibility for their actions. A person is responsible for ceding his independence to another. What does affect responsibility is interference with a person's autonomy when the person is not in a position to realize this is occurring, or to do much about it if he does. If my will is overborne or undermined, then the responsibility for what I have done shifts to those who have interfered with my autonomy.

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[12] R. P. Wolff, In Defense of Anarchism (New York: Harper & Row, 1970), p. 14.

The Value of Autonomy in Informed Consent

I have argued so far that the concept of autonomy plays a major role in arguments about the requirement of informed consent but I have not yet said very much about why the promotion of autonomy is something to be desired and valued. This question is made more difficult by the particular conception of autonomy I have presented. For a conception of autonomy that has no particular content, that allows for the possibility of a patient granting complete authority to a doctor, seems too formal to be of great value. I shall argue now that it is precisely because autonomy has this relatively weak and formal character that it can play a fundamental role in moral theory.

Let me begin by considering at the most general level what is involved in that form of practical reasoning we single out as moral reasoning. Every moral theory has some conception of equality among moral agents, some conception according to which we are to regard others as equal to ourselves. For the utilitarian, equality is represented in the theory by the claim that in calculating utility the interests of each person are to count equally. For the natural rights theorist, all persons are assumed to have equal rights. For the Kantian, I may act only in that way that I am prepared to will all others act. For the religious moralist we are all children of God.

Corresponding to these notions of equality are various devices for preserving this fundamental equality in the process of moral reasoning. According to the utilitarian an action is justified when an impartial observer would view the action as maximizing the total amount of utility in the given community. For the rights theorist and the Kantian a justification must be acceptable to each of the individuals affected. A similar motive underlies the Golden Rule that is found in most major religious theories.

Underlying the various techniques of moral justification is a prohibition against treating others in such a way that they cannot share the purposes of those who are so treating them. And behind this is a conception of the nature of persons as independent sources of moral agency. It is as distinct loci of consciousness, of purposive action, as distinct selves, that others must be respected and taken into account when each of us decides what he shall do. It is because other persons are creators of their own lives, are shapers of their own values, are the originators of projects and plans, that their interests must be taken into account, their rights respected, their projects valued.

What makes an individual the particular person he is reflects his pursuit of autonomy, his construction of meaning in his life. One can see, therefore, a number of reasons why autonomy is a relatively contentless notion. People can give meaning to their lives in innumerable ways. There is no particular way of giving shape or meaning to a life. This, of course, is compatible with certain lives being more admirable than others. In addition, any feature that is going to ground an equality of respect must be a feature that persons share, that they have in common. Any particular way of filling in the content of a life plan is not likely to be shared. Morality is owed to everyone. More intimate relationships such as friend or lover must respond to the particular qualities of another, to lives shaped in specific fashion. Moral respect is owed to all because all have (assuming we are dealing with normal persons, not defective or incompetent in serious ways) the capacity for autonomous development.

Now it is true that while all (normal) persons have such a capacity it is not the case that all have an equal capacity. Like any other capacity—say, the ability to identify with the pain of others—it is a product of one's biological and environmental circumstances. Our conception of a moral agent is of a creature who possesses this capacity above some significant threshold. That some persons will be very much above this level is not important, morally speaking, although it may be important for some purposes.

This first part of my argument has been directed to showing that a weak notion of autonomy is connected to central parts of ethical reasoning. It is also linked to important metaphysical and attitudinal features of moral agents. Our idea of who we are, of our self-identity, is linked to our ability to find and refine ourselves. The exercise of the capacity of autonomy is what makes my life mine. And, if I am to recognize others as equal persons, there is a requirement that I give weight to the way they define and value the world in deciding how I should act.

One argument, then, for the value of autonomy is that we have a conception of persons that is deeply rooted in our world view, and that this conception is worthy of respect and admiration. A full analysis of why the capacity for autonomy is worthy of respect would require a general theory of value (worth) and of morality (respect). I have neither but I shall make some comments about the value of autonomy.

Arguments for the value of anything may claim either that something is good because it leads to something else that is good (instrumental value) or because it is good for its own sake (intrinsic value). Autonomy has value along both dimensions.

On instrumental grounds being able to shape one's own choices and values makes it more likely that one's life will be satisfying than if others, even benevolent others, do the shaping. This is the traditional liberal argument that people are better judges of their own interests than others. Though debate goes on about the limits to which this is true, as a rough generalization it is highly probable.

There is also the fact that quite aside from what results from determining one's life, people get satisfaction out of doing so. We should not overlook the extent to which the process of thinking about, reflecting upon, choosing among preferences is a source of satisfaction to individuals.

But there is value connected with being self-determining that is not a matter either of bringing about good results or the pleasures of the process itself. This is the intrinsic desirability of exercising the capacity for self-determination. We desire to be recognized by others as the kind of creature capable of determining our own destiny. Our own sense of self-respect is tied to the respect of others—and this is not just a matter of psychology. Second, notions of creativity, of risk-taking, of adherence to principle, of responsibility are all linked conceptually to the possibility of autonomous action. These desirable features of a good life are not possible (logically) for nonautonomous creatures. In general, autonomy is linked to activity, to making rather than being, to those higher forms of consciousness that are distinctive of human potential.

It should not be denied that in addition to the instrumental gains of exercising autonomy there are also instrumental losses. With responsibility comes blame and punishment. With the possibility of adherence to principle comes the possibility of cowardice and betrayal. It is not part of my thesis that more autonomy is always better than less. I have only been trying to understand why autonomy has value when it does.

The Special Role of Autonomy in Health Care

I turn now to the question of whether autonomy plays some special role in the health-care context. We know that there are various professional relationships that attach significance to the autonomy of the client. A psychiatrist may point out the destructive aspects of a marriage but ought not to pressure his patient to terminate it. Architects must walk the fine line between respecting the wishes of the client and attempting to educate and refine his taste in houses. Is autonomy more important in the doctor-patient relationship than in these other cases? I believe there is something special about the health-care context that emerges from an accurate conception of the doctor's role.

It is a truism that a doctor cares for the health of the body. It is also a truism that persons are embodied creatures; meaning not merely that we have bodies but that we are bodies. From these truisms it follows that the care of our bodies is linked with our identity as persons. Whatever goals or values we have are tied up with the fate of our bodies. Health is, as Rawls puts it, a primary good, a good that any person wishes to preserve and promote whatever the more specific details of his life plans. The function of medical care has been put most succinctly by Charles Fried.

> [T]he doctor's prime and basic function is not so much the prevention of death (which is not in his power) but the preservation of life capacities for the realization of a reasonable, realistic life plan. As in particular cases conflicts arise and decisions must be made between various capacities and between the risk of death and the impairment of various capacities, the doctor must see himself as the servant, not of life in the abstract, but of the life plans of his patients.[13]

Decisions about what form of treatment to undergo, the probabilities of cure and of side effects, judgments about how the body will look to others after various forms of surgery, whether to spend one's last days in a hospital or at home—these are not technical, medical judgments. To suppose that these are matters of expertise, decisions to be taken by experts, represents a denial of autonomy that is particularly damaging for two reasons.

First, one's body is irreplaceable and inescapable. If my architect doesn't listen to me and this results in a house I do not like, I can always move. I cannot move from my body. In addition since my body is me, failure to respect my wishes concerning my body is a particularly insulting denial of autonomy. Of course the opposite side of this coin is also true. If the denial of autonomy is justified in terms of promoting the benefit of my body then paternalism would seem to have the strongest claim in the medical context. This brings us to the issue of possible exceptions to respecting the autonomy of patients.

Possible Exceptions to Respecting Patients' Autonomy

Thus far I have argued that autonomy plays a major role in explaining the doctrine of informed consent and I have given reasons for the importance we attach to autonomy. But nothing I have said commits me to the view that respect for autonomy is, or ought to be, absolute. There are certainly other values that are of fundamental moral importance and of crucial significance to any person. These include dignity, health, well-being, integrity, security. It is possible that in order to promote any of these values it may be necessary to sacrifice some autonomy. It is also possible that promotion of autonomy in the long run requires sacrificing autonomy in the short run. Finally there are cases in which a person is already in a nonautonomous state or one of diministed autonomy and the principle ceases to have application or at least its application is more problematic than in normal cases. These seem to me the grounds for considering exceptions to the doctrine of informed consent—conflicting values and reduced autonomy—and I want to indicate the framework of moral justification that I think is appropriate for discussing the limits to principles we judge to be, at first approximation, the correct ones. I shall not argue for this framework—indeed it is not clear that such a basic outlook can be argued for—but simply present it in the hope that it will strike the reader as plausible and attractive.

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[13] C. Fried, MEDICAL EXPERIMENTATION: PERSONAL INTEGRITY AND SOCIAL POLICY (Elsevier, 1974), p. 98.

Moral reasoning is a branch of practical reasoning, i.e., reasoning about what to do as opposed to how things are. Unlike other kinds of practical reasoning, e.g., prudential thought about what will promote my long-range welfare, it is tied to the existence and recognition of other persons. Just as prudential reasoning is constrained by the recognition that there is a future self whose interests must be taken into account, moral reasoning is constrained by the recognition that there are other persons whose interests are no less important to them than mine are to me. Moral reasoning is the attempt to give reasons for action that are acceptable to other independent and equal moral agents. We seek general principles for the regulation of behavior that are such that they can command the agreement of other informed, rational, and free agents. The test of a proposed principle or action is that it would be found acceptable not just to the person who proposes it but to all those whom the action affects. Justification is to others; moral motivation, the connection of morality with our will, is supplied not by sympathy alone but by our need to act in such a fashion that our actions are both understandable to ourselves and acceptable to others.

This view is a species of meta-ethical theory traditionally labeled as contractualist. It is a meta-ethical view because it says nothing directly about the content of the moral principles that are justified contractually. It is possible that the principles that are capable of being agreed to will be similar to those of utilitarians or Kantians or natural law theorists. But it is the agreement to the principles that grounds them and not the reasons for the agreement. Whatever its other merits on purely philosophical grounds such a contractualist scheme of justification is particularly appropriate for our problem—the exceptions to the doctrine of informed consent. On this view the exceptions must be capable of being justified to those whose consent will not be sought or honored. Naturally, to present this justification in the very context in which the issue arises would be self-defeating. If, for example, one believes that presenting a patient with the true facts of his diagnosis would be psychologically damaging one could hardly justify this failure to inform by stating to the patient that he would be harmed by telling him the truth of his condition. The justification, if there is one, must lie in a general agreement that is ex *ante*, which occurs or could occur before we are faced with the situation to which the exception applies. We have to deliberate about and agree upon the merits of exceptions to a principle (whether there are any and how broad they should be) in abstraction from the particular set of facts. This is not to say, of course, that a doctor faced with a real case is barred from thinking about the issue. It is to say that his thought ought to reflect, in the logic and the range of considerations he considers relevant, the position of persons who are to settle upon rules prior to their being faced with specific moral conflicts.

Exceptions to the Requirement of Informed Consent

The candidates for exceptions to informed consent can be grouped under the headings of emergency, incompetence, waiver, and therapeutic privilege.[14] The first two are relatively unproblematic in principle although they may pose problems in practice of determining when they apply. Waiver is, I shall argue, not an infringement of autonomy at all. Therapeutic privilege is the exception that most directly infringes autonomy and raises the greatest problem for justifying an exception.

It is surely rational for autonomous persons to agree that life-saving treatment may be rendered without the consent of the patient in "emergency" situations. An emergency situation is one in which the patient is unable to give consent or to receive information. If a patient should object to this treatment afterwards there is a clear justification that can be presented to him. "I acted to preserve your possibility of future autonomous action," says the doctor, "and I did so in conditions such that you could not give your consent, and in which to wait until you could would be impossible."

Note here that it is not just that important benefits for the patient are produced but that there is no reason to suppose the patient did not want the benefits *and* there was no possibility of getting consent. We have a great benefit (life) secured without any loss of autonomy. For us not to agree to such a bargain is irrational.

The possibility of broadening the concept of an emergency then arises. Suppose that it is not life but, say, limb that is at stake and consent is not impossible but costly (where cost might be defined in terms of the time necessary to get agreement). Let us suppose we have a person with a detached hand that could be reattached by immediate microsurgery. And let us suppose that the person only speaks Serbo-Croatian and the time necessary to get a translator would make the operation ineffective. Again the *ex ante* justification seems clear. Our interest in our limbs is an important one; the violation of autonomy, while greater than in the previous case (because it is possible to get consent), is minor.

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[14] I am indebted to Meisel, *op. cit.*, for his classification of the exceptions to informed consent.

Proceeding in this manner—by varying the nature of the harm to be averted as well as the costs of obtaining informed consent—we should be able to get a fix on the limits of the emergency exception. It seems plausible, for example, that there will be cases where we will insist upon consent but not upon full information (which is time-consuming and which may not be effective in conditions of great stress and pain). I do not insist that this scheme will give unique solutions. There may be hypothetical cases in which reasonable people will disagree about what rule they would agree to in advance of an emergency. Those may be precisely the cases that we leave to other institutions, such as courts, to decide on a case-by-case basis after the fact.

It is sometimes said of emergency cases that the patient has "implicitly" or "tacitly" agreed to the treatment, and hence there is no violation of autonomy. This way of talking is misleading. It suggests that there is really some consent that has taken place but one just has to know where to look for it. In fact, neither explicitly nor implicitly has any agreement taken place; if there is no loss of autonomy in these situations by not getting consent it is because autonomy has already been lost and not because the patient has really consented. My argument does not rely on any supposed agreement but on a set of principles that are justified because they are capable of securing agreement by rational agents under certain circumstances.

In the typical emergency situation, where the patient is unconscious and cannot give consent, the patient is also incompetent. The case of a psychotic patient or a senile patient or an infant are also cases where consent is impossible but here it is not a temporary problem. Again, on the level of theory, the situation does not seem too difficult. Here the problems are ones of definition, of drawing the line, of determining who ought to be authorized to consent for the patient, and what criteria should that authorized patient use. The theoretical justification is identical to the emergency case. Given that we all know we are subject to various incompetencies and that decisions may have to be made with great impact on our life chances, it is reasonable for us to "insure" against loss by authorizing health care when we are not able to do so. The case of incompetency is one in which our autonomy has already been impaired, lost, or not developed so there is no denial of autonomy on the part of the doctor. It is true there are other harms that may be inflicted on us. We may be kept alive in conditions that are insults to our dignity or privacy, and once aware of this we may want to establish limits to the treatment that is permissible without our explicit consent. But to deny any exception to the securing of informed consent, even in cases where we are not competent, would be self-defeating.

The next exception, that of waiver, is conceptually quite a distinct category. Like self-defense in the law, it ought to be considered a justification, not an excuse. It is not like the previous cases of emergency or incompetence in that one fails to get informed consent; it is that one ought not to try. If a patient has knowingly and freely requested of the doctor that he not be informed or consulted about his course of treatment then to seek to obtain informed consent would itself be a violation of autonomy. Again the difficulty is a practical one—determining that the waiver is not simply psychological denial or a process of infantilization or of giving in to the pressures of the doctor. Leaving these difficult problems aside, as I argued earlier, autonomy includes the possibility of a decision to give up one's independent determination about what one should do. While this decision may be foolish or unwise it can hardly be interfered with on the grounds of autonomy. If one denies the legitimacy of waiver this will be on the grounds that it is better for the patient not to act in this manner. And this brings us to the issue of paternalism and the last category—therapeutic privilege.

Therapeutic privilege may be conceived as the opposite side of the coin of waiver. In waiver the patient decides that certain information will be harmful or cause distress and that he would be better off not having it. In therapeutic privilege the doctor decides that securing informed consent would be harmful to the patient and that he is better off not having it. It is a privilege since it allows exemption from a duty; it is therapeutic since it is intended for the benefit of the patient. This exception raises the clearest conflict between the value of autonomy and what is considered the best interests of the patient.

Using the framework of seeking general agreement by all the relevant parties, the issue becomes what powers to ignore our consent can we agree to grant health professionals when they claim that seeking such consent would be harmful to us. It is useful to consider a spectrum of positions ranging from weak to strong powers.

The weakest position is that autonomy may be denied only in the interests of the autonomy of the patient. This exception would allow a doctor to withhold information only when a special harm would (be likely to) follow from the disclosure of information, namely, that harm that would result in the patient's being unable or being less able to make an autonomous decision about his treatment. This justification is invoked in Canterbury v. Spence, when the court claimed the failure to disclose was justified because "it is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision."[15] Such an exception is maximally coherent with the principle of informed consent since it claims that the disclosure would in fact undercut the worth of the consent. Of course the fact that a doctor claims this harm would occur does not make it true, and there remains the problem of designing institutions to make the ratio of true claims as high as possible and to provide remedies for those denied their autonomy when the claim is unwarranted by the available evidence. Nevertheless this exception seems to be one we can all accept since it is justified in terms of the promotion of the value fostered by the principle to which it is an exception.

There is the much broader version of harm invoked by therapeutic privilege that is also present in another line of reasoning in Canterbury. On this view failure to disclose was justified because "risk disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view."[16] Here one can distinguish two ways in which such information might be contraindicated. In one case the disclosure has a direct harmful effect on the emotional state of the patient. He is distraught when he learns he has cancer or Hodgkin's disease. In the other kind of case the harm operates primarily via its effect on the treatment decision made by the patient. The doctor believes that disclosure would lead the patient to choose a form of treatment that is not optimal or perhaps even detrimental. Note that this is not equivalent to asserting the patient cannot make a rational or autonomous decision; it is a claim that the decision is wrong or mistaken.

What would be the results of allowing doctors to have the power to deny our autonomy when they believed that harm in one of these two forms would result? According to the mode of justification that I have been using such powers must be publicly recognized and acknowledged. Granting such authority to doctors must undermine the atmosphere of trust between doctor and patient, for the doctor could not for long simply remain silent but would have to mislead and, in many cases, lie. We would all be in a state of uncertainty about the meaning and truth of the communications from doctor to patient.

Given the possibility of explicit waiver, given the state of dependency to which illness reduces us in any case, given the erosion of trust produced by such an exception, and given the difficulty of effective restraints on the use of such powers, the resulting loss of autonomy created by the wide exception of therapeutic privilege is too great to secure general agreement among all those concerned. Competent patients have the right to the information necessary to make those evaluative, nontechnical decisions about their bodies that autonomy requires.

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[15] Canterbury v. Spence, at 789.

[16] *Ibid.*

Let me end by mentioning one final distinction. One may view the requirement of informed consent as connected to autonomy in either of two ways. In the first it is related as cause and effect. We suppose the requirement is, as a matter of fact, likely to promote the autonomy of patients. I believe the evidence is in favor of this proposition but it is an empirical claim subject to refutation. There is another way of viewing the connection, which sees the attempt to secure consent as itself being an expression of respect for the autonomy of the patient. On this view the connection is a necessary one. One way of showing respect for a person is by seeking his willing acceptance of a plan of treatment. Seeking consent is an expression of respect for autonomy in the way that apology is an expression of regret. To fail to seek consent, as in the case of therapeutic privilege, is necessarily an insult to autonomy even though motivated by pure benevolence.

portion of that produced by such an exception, and given the possibility of effective treatment [illegible] of such powers, the resulting loss of autonomy [illegible] exception of therapeutic privilege is too great to secure general agreement, all those concerned. I can agree patients have the right to the information necessary to make these [illegible] technical decisions about their bodies that [illegible].

Let me end by considering the final objection. On this view the requirement of informed consent is related to autonomy in either of two ways. In the first it is related as cause and effect. We suppose the requirement is as a matter of fact likely to promote the autonomy of patients. I believe the evidence is in favor of this proposition but it is an empirical claim subject to refutation. There is another way of viewing the connection, which sees the attempt to secure consent as itself being an expression of respect for the autonomy of the patient. On this view the connection is a necessary one. One way of showing respect for a person is by seeking his willing acceptance of a plan of treatment. Seeking consent is an expression of respect for autonomy in the way that apology is an expression of regret. To fail to seek consent, as in the case of therapeutic privilege, is necessarily an insult to autonomy even though motivated by the benevolence.

Psychological Issues in Informed Consent

H

William C. Thompson*

Introduction

Concern that doctors exercise too much control over medical decisions has been a primary motivation for the expansion of informed consent requirements in recent years.[1] Many people believe doctors make decisions for patients that would better be made by the patients themselves.[2] Others have expressed fear that doctors involve people in research without allowing them to make an informed choice of whether to participate.[3]

Control by doctors over what treatment is given or who becomes a research subject has two basic disadvantages. First, it undermines patients' autonomy. (The term patient is used throughout this paper, although the discussion applies equally to subjects of medical research.) The law has long recognized that people have the right to decide for themselves what should be done to their bodies.[4] Allowing someone else to make such decisions, even when the decisions are "in their best interest," is viewed as undermining people's integrity. Patients do not forfeit this right to decide when they seek a doctor's care. The doctor's role is to advise a patient of treatment options and to administer treatments the individual decides to receive. The ultimate decision about what treatments should be given remains with the patient.[5] A second disadvantage of doctor control is that it may undermine patients' welfare. Allowing doctors to decide what interventions people will undergo creates a danger that the decision will not be in the patient-subject's best interest. Doctors may have ulterior motives that influence the choices they make for patients.[6] Even if the doctor decides in good faith, the decision may not be optimal from the patient's perspective because the doctor's view of what is best may differ from that of the patient.[7] Insuring that those who bear any risk of an intervention have the final decision as to whether or not it is performed is viewed as the best way to maximize their welfare.

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[1] See Annas, Glantz, and Katz, Informed Consent to Human Experimentation, Ch. 1,2 (1977).

[2] See Barber, Informed Consent in Medical Therapy and Research (1980).

[3] Beecher, Research and the Individual (1970).

[4] In Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914) Judge Cardozo made an observation every treatise on informed consent is obliged to quote: "Every human being of adult year and sound mind has a right to determine what shall be done with his own body . . . "

The doctrine of informed consent is the device the law employs to ensure that patients maintain control over medical decisions that affect them. It has long been accepted that doctors must inform patients and gain their consent before performing any medical intervention.[8] In recent years, case law and statutes have added a great deal of definition to that requirement.[9] New laws have specified, for example, the type of information doctors must disclose in order to "inform" the patient.[10] These developments were parallelled by the creation of Federal regulations specifying informed consent requirements for research supported by Federal funds.[11]

Do the current laws effectively protect patients' autonomy and welfare? This paper begins with the premise that for informed consent to fulfill these underlying purposes two conditions must be met. First, patients must be able to make an accurate assessment of the risks and benefits of the proposed intervention. If patients fail to understand or misconstrue the probable consequences of their medical decisions, allowing them to make those decisions may not protect their best interests.[12] Second, patients must be able to choose freely whether the intervention should be performed. If patients are unable to assert their own preferences in the face of social pressures in the medical setting, leaving the decision nominally in their hands does not protect their autonomy.[13]

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[5] For extended discussion of doctor and patient roles with regard to informed consent see Veatch, *Models for Ethical Medicine in a Revolutionary Age*, 2 HASTINGS CTR. RPT. 5 (1972); May, *Code and Covenant* or *Philanthropy and Contract*, 5 HASTINGS CTR. RPT. 29 (1975); Barber, *supra* note 2.

[6] Doctors administering therapy may accrue greater financial benefits from some courses of therapy than from others, a fact that may distort their decisionmaking when the most lucrative options are not the best for the patient. Researchers' interest in producing results may conflict with their obligation to protect subjects. See Beecher *supra* note 3, at 16.

[7] Katz and Capron, CATASTROPHIC DISEASE: WHO DECIDES WHAT? (1975) at 89.

[8] Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).

[9] See Miller, *Informed Consent* (Pts. 1-3), 244 J.A.M.A. 2100, 2347, 2556 (1980); Ludlam, INFORMED CONSENT (1978).

[10] Cobbs v. Grant, 8 Cal.3d 229, 502 P.2d 1 (1972).

[11] 45 CFR § 46.116 (1981).

In this paper I will argue that current law is inadequate to assure that these two requirements of informed consent are met. First, I will argue that current law does not guarantee that informed consent disclosures will be made in a way that enables patients to form an accurate assessment of the risks and benefits involved. I will base this argument on psychological research showing that people's risk assessments are strongly influenced by the form and manner in which information about risks is presented. Information with the same objective content can lead people to strikingly different conclusions when it is presented in different ways. Because current law leaves control over the form and manner of disclosures largely in the hands of physicians and experimenters, it is possible for them to manipulate (either intentionally or inadvertently) patients' perceptions of risks and benefits and thereby exert considerable influence over their decisions.

Second, I will argue that current law is inadequate because it allows physicians and experimenters to exercise a degree of influence over people's decisions that is so extensive as to call into question the assumption that these decisions are freely made. I will base this argument on social psychological research that suggests that patients' decisions about medical interventions are likely to be highly malleable and that people are vulnerable to influence attempts by doctors. Finally, I will suggest ways the law might be changed in order to help patients assess the risks and benefits more accurately and choose more freely.

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[12] Many commentators have suggested that informed consent is not sufficient to protect the welfare of mental incompetents and children. Annas, Glantz, and Katz, *supra* note 1, at 63-101. Such individuals are thought incapable of understanding their choices well enough to be trusted to act in their own best interest. The law assumes that normal adults are competent to determine what is in their best interest. That assumption is examined, in part, in this paper.

[13] The issue of patients' freedom of choice typically arises in discussions of therapy and research on institutionalized populations. Annas, Glantz, and Katz, *supra* note 1, Ch. 4,5. Commentators have recognized that prisoners and mental patients may be in situations that are so coercive that free choice is unlikely, if not impossible. *Id.* Informed consent is not sufficient to protect autonomy in such situations because patients' choices are made in response to external pressure rather than being self-motivated. This paper will argue that external pressures akin to those that bear on institutionalized populations may also be brought to bear on non-institutionalized patients, raising doubts, in some instances, about the adequacy of current informed consent procedures to protect their autonomy.

Limitations on Patients' Capacity to Draw Accurate Conclusions from Informed Consent Disclosures

Overview. The scholarly literature on informed consent contains much discussion of people's capacity to understand informed consent disclosures.[14] But most of this discussion takes place at the level of assertion and counterassertion. Statements about the possibility of "informed" consent and about methods of best assuring it are based on common sense and intuitive judgment rather than empirical research. A few naturalistic clinical studies have been conducted to determine what doctors actually tell patients and how well patients understand those disclosures.[15] The general findings—that patients often fail to remember and perhaps fail to understand what they have been told—are interesting and important, but do not resolve the basic question of patients' *capacity* to exercise informed consent. People's failure to understand a particular disclosure may result from inadequacies in that disclosure rather than inadequacies in the patient. Hence these studies do not tell us whether patients are capable of understanding when properly informed, nor do they tell us how doctors might convey a more adequate understanding. In seeking answers to these broader questions we must be guided, I believe, by an understanding of the psychological processes by which people interpret information when assessing risk. This section describes research on some of those processes and applies the findings to the issue of informed consent.

Over the past 30 years there has been a great deal of research on people's ability to make judgments on the basis of complex information.[16] This literature on human decisionmaking and judgment now comprises literally thousands of studies. Perhaps the major conclusion that can be drawn is that there are some striking inadequacies in the way people use information to make judgments and draw inferences. One major reviewer of the literature concluded that "human decisions are characterized by biases and inconsistencies that can lead to markedly non-optimal behavior."[17] Another conclusion is that "people systematically violate the principles of rational decision making when judging probabilities, making predictions or otherwise attempting to cope with probabilistic tasks."[18] These findings have resulted in "an increased concern with the deficiencies of unaided human judgment, deficiencies that seem to result from a limited ability to integrate complex information."[19]

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[14] Katz and Capron, *supra* note 7, at 90; Barber, *supra* note 2, at 78.

[15] Priluck, Robertson, and Buettner, *What Patients Recall of the Preoperative Discussion After Retinal Detachment Surgery*, 87 AM. J. OPTHAMOL. 620 (1979); Robinson and Merav, *Informed Consent: Recall By Patients Tested Post-Operatively*, 22 ANN. THORAC. SURG. 209 (1976).

[16] For reviews, see Slovic, Fischhoff, and Lichtenstein, *Behavioral Decision Theory*, 28 ANN. REV. PSYCHOL. 1 (1977); Nisbett and Ross, HUMAN INFERENCE (1980).

The most disturbing feature of these findings for informed consent is that people's judgments and inferences are often highly malleable. It is a fundamental premise of logic that the truth value of a proposition remains the same regardless of how the proposition is expressed. But this premise does not describe the way people respond to information. Seemingly minor variations in the way information is presented can often have a dramatic effect on the conclusions and inferences people draw from it.[20] This suggests that the way informed consent disclosures are made may have an important effect on people's evaluation of the risks and benefits posed by an intervention, which, in turn, may strongly influence their decision about whether to consent. Furthermore, the accuracy of the conclusions people draw from information varies with the nature of the information and the manner in which it is presented. To design informed consent disclosures in such a way that they allow people to make an accurate assessment of the risks and benefits involved in a procedure, we must be aware of limits on people's ability to deal with complex information.

Misuse of Information: How We Know People Are Wrong. Much of the research discussed below attempts to evaluate the way people use information to assess risks. In discussing this research I will argue that some of the conclusions people draw about the risks they face are appropriate and correct, while other conclusions are wrong, misguided, or irrational. Some people maintain that it is impossible to assess fairly the rationality of another person's use of information. To say that a person is using information irrationally, they argue, is merely to say that we disagree with the conclusions that person draws from the information. A disagreement as to particular conclusions, however, may result from differences in tastes or values rather than from any irrationality in the way the information is used. According to this argument, "irrational" is simply a conclusory label we apply to people whose tastes and values differ from our own. Attempts to assess the rationality of others, then, are at best paternalistic and at worst tyrannical.

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[17] Slovic, Fischhoff, and Lichtenstein, *supra* note 16.

[18] Slovic, Fischhoff, and Lichtenstein, *Cognitive Process and Societal Risk Taking*, in Carroll and Payne (eds.) COGNITION AND SOCIAL BEHAVIOR (1976).

[19] Pitz, *Sensitivity of Direct and Derived Judgments to Probabilistic Information*, 65 J. APP PSYCH. 164 (1980).

[20] Tversky and Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, 185 SCIENCE 1124 (1974).

Although this argument expresses a legitimate concern, it addresses a larger issue than is of concern in this section of the paper. First, at this stage the inquiry focuses only on people's ability to assess accurately the risks and benefits of a medical intervention, not on their decision about whether to undergo an intervention posing a given set of risks and benefits. The decision to consent to an intervention is, I believe, a two-step process in which a person first assesses the risks and benefits of the intervention and second decides whether the benefits outweigh the risks enough to make the intervention worthwhile. In this section, the inquiry focuses exclusively on the first step in this process.

People' assessments of the risks and benefits posed by an intervention can, I believe, be evaluated by objective standards by considering their ability to draw appropriate inferences from (1) base-rate information, i.e., information about the likelihood of a given event among members of a certain category; (2) case information, i.e., examples, single instances, small samples; (3) probabilities stated in quantitative terms; and (4) nonquantitative verbal expressions of likelihood. Two standards will be used to judge the rationality of people's inferences. Their use of base-rate and case information will be judged by its consistency with scientific and statistical norms of inference. These norms, which have developed through centuries of scientific research, dictate what types of inferences are permissable from various types of information.[21] Following the standard approach taken by researchers who study decisionmaking, I will label people's uses of information inappropriate or irrational when they draw conclusions that would not be drawn by a person evaluating the information according to the formal tools of scientific inquiry.[22] People's use of probabilistic information will be judged according to a standard of logical coherence. This standard looks to the internal consistency of people's inferences and judgments and holds that people are using information inappropriately or irrationally when they draw inconsistent or contradictory conclusions from it. The consistency of people's conclusions is assessed according to the laws of probability.

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[21] Nisbett and Ross, *supra* note 1, at 8, point out that many inferential tasks that confront people in daily life are directly analogous to those confronting a scientist. People gather "data" about the world, then use it as an evidentiary base for generalizing to some population of events or objects. People assess covariation between events, theorize about causal relations, and use their theories to predict future events. Scientists have well-developed rules for carrying out these inferential tasks. Hence, the appropriateness of people's everyday inferences can be judged by seeing how well they accord with the inferences that would be made by an idealized "scientific mind" that applied the formal tools of scientific inference to the available information.

Underuse of Base-Rate Information. Suppose you have been experiencing headaches, dizziness, and blurred eyesight. The doctor at the health center tells you your symptoms are probably just the result of reading too much, but advises you nevertheless to see a neurologist because reports in the medical literature indicate that 10% of patients with symptoms identical to yours have a brain tumor. The neurologist gives you a diagnostic test that is claimed to be 80% accurate in detecting brain tumors. Questioned on the accuracy rate, the neurologist explains that a recent study published in the A.M.A. JOURNAL validated the test on 200 patients, half of whom were known to have tumors and half of whom were known not to have tumors. The test correctly identified 80 of the 100 patients with tumors by showing a positive result, and correctly identified 80 of the 100 patients without tumors by showing a negative result—an 80% accuracy rate that, the neurologist says, makes this the most accurate test available for detecting brain tumors. You undergo the test and the results are positive. The neurologist suggests you consider brain surgery. Although such an operation is extremely hazardous and may not be necessary (as the test results do not conclusively prove you have a tumor), failure to operate, should you actually have a tumor, is even more hazardous. Your decision on whether to undergo the operation or not obviously depends heavily on your estimate of the probability you actually have a tumor. Based on the information the doctors have given you, what is your best estimate of that probability?

Problems of the type just described require an evaluation of two types of information: base-rate information and diagnostic information. Base rates provide information about the likelihood of a given event among members of a certain category. In the example above the base rate for brain tumors among people with your symptoms is .10 (10%). Diagnostic information is any information relevant to an event likelihood for the specific entity with which we are concerned. In the example above, you are the entity of concern and the neurologist's diagnostic test provides "diagnostic" information[23] about the likelihood of a tumor in your particular case.

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[22] For example, in predicting the outcome of an event, scientific rules dictate that base rates (i.e., relative frequencies of the outcome possibilities) be taken into account. If people know about base rates but their decisions seem not be influenced by that knowledge, their decisions are counternormative and should be labeled irrational. This point is pursued later.

A great deal of recent work in the decision literature has studied people's use of base-rate and diagnostic information in various contexts. The general finding is that people tend to ignore base-rate information and focus most of their attention on diagnostic information.[24] This means people are less influenced by base rates than normative statistical models indicate they should be. In the brain tumor example, for instance, normative statistical models of decisionmaking suggest the base-rate information is very probative. According to statistical norms this problem should be analyzed by applying a statistical formula called Bayes theorem, which takes into account both base rates and diagnostic information.[25]

According to Bayes theorem the best estimate of the likelihood that you have a tumor is .31 (31%). If the estimate you made was higher than .31, you probably committed the inferential error of underutilizing base-rate information. Among people with your symptoms, 10% are normally found to have a tumor. Suppose 100 people with your symptoms were given the neurologist's 80%-accurate diagnostic test. Ten would actually have a tumor and eight of them would be detected by a positive test. Ninety of the 100 people would not have a tumor, but the test would show a "false positive" to 18 of them (20%). Thus the test would give positive responses to 26 of the 100 people, but only 8 of the 26 would actually have a tumor. A given individual, like yourself, who received a positive response would have 8 chances in 26 (or a 31% chance) of having a tumor.

Although people underuse base-rate information in a variety of different contexts, they do not always do so. Base-rate information like that in the tumor example is quite likely to be ignored. On the other hand, information on the success rates of operations is likely to be used appropriately. The literature on people's use of base rates is full of exceptions and counterexceptions to every rule. Reviews of the reasons people misuse base rates and of the types of base rates most likely to be underused can be found in Nisbett and Ross[26] and Kahneman and Tversky.[27] Overall, nevertheless, underuse of base rates is frequent, pervasive, and quite likely to lead patients to erroneous conclusions in many cases. Nor are they the only ones to be misled. Doctors appear to misuse base-rate information also. One recent study of doctors' skills at identifying disease found they systematically overused information from diagnostic tests and underused base-rates, especially when attempting to diagnose low base-rate diseases like cancer.[28]

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[23] Kahneman and Tversky, *On the Psychology of Prediction*, 80 PSYCH. REV. 237 (1973).

[24] *Id.*

[25] *Id;* Tversky and Kahneman, *Causal Schemata in Judgment Under Uncertainty*, in Fishbein (ed.), PROGRESS ON SOCIAL PSYCHOLOGY (1978).

[26] *Supra* note 16.

[27] *Supra* note 23.

Overreliance on Case Information. Striking examples, vivid case studies, and the like are typically observed to have far greater influence on people's inferences than normative models say they deserve. A basic limitation on people's ability to use information rationally is their tendency to act as if examples were proof.[29]

Research on this phenomenon usually takes the form of an evidentiary contest in which people receive various types of information and the experimenters note which type has the greatest impact on people's inferences, judgments, and decisions. A study by Borgida and Nisbett, for example, examined how two different types of information influenced undergraduates' choices of what psychology courses to take.[30] Some students were given detailed statistical data summarizing the course evaluations of all students who had previously taken the courses. Others heard and saw one or two students who had previously taken each of the courses give verbal evaluations of the courses. The verbal evaluations included no objective information that was not also included in the course evaluation summaries. Thus the "contest" was between statistical data on how hundreds of students had rated courses (such as good, fair, or poor) on various dimensions and the verbal statements of one or two students. Normative statistical models indicate the course summaries were far more probative than the verbal evaluations. One seemingly learns more about a course by knowing how all the students evaluated it than by knowing how one or two students evaluated it. But Nisbett and Borgida found that students' subsequent course selections had been influenced far more by the verbal evaluations than by the statistical summaries.

A similar study by Hamill, Wilson, and Nisbett examined how people's attitudes toward the welfare system were influenced by various types of information.[31] They found that a single case study describing in detail a "welfare chiseler" who stayed on welfare interminably had much greater influence on people's attitudes toward the welfare system than did statistical data on the operation of the system as a whole. In particular, people's estimates of length of average stay on welfare were powerfully influenced by the case study. Statistical breakdowns showing average duration of stay on welfare for an entire city had relatively little influence on people's estimates.

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[28] Shortliffe, UTILIZING THE JUDGMENTAL KNOWLEDGE OF EXPERTS IN MEDICAL DECISIONMAKING.

[29] See Nisbett and Ross, *supra* note 16, Ch.3.

[30] Borgida and Nisbett, *The Differential Impact of Abstract vs. Concrete Information on Decisions*, 7 J. APP. SOC. PSYCH. 258 (1977).

[31] Hamill, Wilson, and Nisbett, *Ignoring Sample Bias: Inferences About Collectivities from Atypical Cases*, unpublished manuscript, University of Michigan (1979).

This research suggests that when evaluating informed consent disclosures, patients are likely to give disproportionate weight to examples and other case data. Just as a picture may be worth a thousand words, a vividly presented case study may be more persuasive than statistical data on thousands of similar cases. Imagine, for example, that you are suffering from a stomach ulcer and your doctor suggests you have surgery to have it removed. The doctor mentions that there is a 5% chance that complications will develop, necessitating further surgery, but that in 95% of the cases a single operation is sufficient. Beyond that, the operation poses only the usual risks associated with general anesthesia and abdominal surgery, which are quite small. Having decided to have the surgery, you mention your intention to an acquaintance who says: "Oh my God. Don't do it. They performed that operation on my Uncle Harry; it was the beginning of the end. Soon as they took out one ulcer another popped up, then another. Pretty soon they had taken out most of his stomach and a good part of his intestines. Then he started hemorrhaging. It was awful. Poor old Harry. Maybe if he had just lived with the damn ulcer he'd still be alive today."

How much weight does the news about Uncle Harry deserve? Assuming his case was not included among the 5% your doctor already told you about who have complications, the story of Uncle Harry should cause you to revise the estimated likelihood of complications in your case upward by a minuscule amount. Before learning about him your estimate of the likelihood of complications was probably .05. If the 5% figure your doctor gave you was based on 10,000 cases, learning about Uncle Harry should cause you to revise your estimate upward to .0501. Yet the news about Harry would probably have considerably greater influence than that on most people's subjective assessments.

Vivid case examples can be used to encourage people to undergo a medical intervention as well as to discourage them from doing so. A doctor who wanted to convince a patient to undergo a treatment might tell a few glowing "success stories" about other patients who were treated, or a few Uncle Harry-style horror stories about people who refused the treatment.

Why do people give more weight to case examples than normative models indicated they should? First, people generally fail to appreciate what statisticians call the law of large numbers.[32] This law holds that the characteristics of large samples are far more likely to represent those of a population than the characteristics of small samples. Tversky and Kahneman conducted a series of studies showing that "people act as if the law of large numbers also applies to small numbers."[33] In other words, people fail to appreciate sampling variability and act as if small samples, even those with only one or two cases, are more representative of such cases in general than they are actually likely to be.

Second, in many circumstances people fail to appreciate sample bias. Nisbett and Ross review research suggesting that, when drawing inferences from a sample about the population from which it was drawn, people fail to compensate adequately for the fact that the sample was selected in a biased manner and is thus unrepresentative.[34] Third, research in cognitive psychology suggests that the mental procedures our brains adopt for processing information have certain built-in biases that operate to exaggerate the impact of vivid, memorable information on our inferences.[35] Finally, striking case examples seem to gain their power by causing people to think about things they previously ignored or failed to give much thought to.[36] Perhaps learning about Uncle Harry brings home to us that complications really do occur and that we can be among the unlucky 5%.

This final reason for the impact of vivid case information suggests that inferences based on such information are not always "irrational." Ultimately, no one can say whether an emotional decision to avoid surgery based on hearing about Uncle Harry is better or worse than a dispassionate decision based on the doctor's base-rate data. The latter probably leads people to a more accurate assessment of the likelihood of complications, but the former might give them a better feel for what it actually means to have complications. Thus people's evaluations of the risks and benefits of a procedure are quite malleable. To the extent that doctors control the precise content of what is disclosed to patients about an intervention, they can exercise a degree of control over evaluations and thereby influence patients' decisions.

Framing Effects: Problems With Probabilities. When deciding between two risky alternatives, people's choices are often influenced by the way the alternatives are presented or "framed." Framing effects are important because they reveal logical inconsistencies in people's use of probabilistic information. Perhaps more important for present purposes, because identical choices can be "framed" in various ways, the person doing the framing may exert a great deal of influence on people's evaluation of the choice options.

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[32] Tversky and Kahneman, *Belief in the Law of Small Numbers*, 76 PSYCH. BULL. 105 (1971).

[33] *Id.*

[34] Nisbett and Ross *supra* note 16, at 73-89.

[35] *Id.*, Ch. 3.

[36] *Id.*

Certainty effects.[37] Consider people's response to the following choices. In Problem One, 95 people were asked whether they would prefer receiving $3000 with certainty or taking a gamble in which they had an 80% chance of winning $4000. The two choice options are represented below. The numbers beneath each option represent the percentage of subjects who chose each option.

Problem One: ($3000) or (.80 chance of $4000)
Response: 80% 20%

The majority's preference for a certain $3000 over a gamble with an expected value of $4000 represents a type of risk aversion or preference for certainty that is widely observed for many types of gambles. There is nothing irrational about this pattern of choices; it merely indicates that people have a taste or preference for certainty.

In Problem Two, the same number of people were asked which option they would choose if forced to decide between a certain loss of $3000 and an 80% chance of losing $4000.

Problem Two: (−$3000) or (.80 chance of −$4000)
Response: 8% 92%

Here the preference of most people for the latter alternative indicates risk-seeking rather than risk aversion. Taken together, the two problems illustrate a well-documented finding about the effect of certainty on people's response to risk. Certainty seems to increase the unattractiveness of losses and the desirability of gains. Still, there is nothing irrational about these choices; they simply represent a set of tastes for risk-taking.

The problem this pattern of risk preferences creates, however, is that people's choices become inconsistent in situations where the same choice can be framed as either a gain or a loss. In Problem Three, people were told they had just received $1000 and now were asked to choose between a sure gain of an additional $500 or a 50% chance of winning an addional $1000. Most people preferred the certain option.

Problem Three: You receive $1000 and then must choose between
($500) and (.50 chance of $1000)
Response: 84% 16%

A different group of subjects was given Problem Four, which stated they had just received $2000 and now were forced to choose between a sure loss of $500 and a 50% chance of losing $1000.

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[37] The problems described in this section are all taken from Kahneman and Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, Econometrica, in press.

Problem Four: You receive $2000 and then must choose between
(−$500) and (.50 chance of −$1000)
Response: 31% 69%

Note that the nets of the two options in these problems are identical. People must choose between a sure gain of $1500 (the first option in both problems) and a gamble in which there is a 50% chance of getting $1000 and a 50% chance of winning $2000 (second option in both problems). But in Problem Three the majority prefer the first option while in Problem Four they prefer the second.

This type of inconsistency can leave people open to manipulation by those who frame their choices for them. In a choice between two options, one of which has no risk but only moderate benefits and the other of which has high risk but high potential benefits, people's choices may vary dramatically depending on whether the options are presented as prospective losses or prospective gains.

As a medical example, suppose a patient with serious heart disease has two therapeutic options: a regimen of medication that will keep him or her alive but force the individual to restrict normal activities, and a coronary bypass operation that will restore the patient to a reasonably healthy state if successful, but that poses a significant risk of death. A doctor who wanted the patient to choose the medication could frame the two choices as prospective gains by saying something like the following:

> Look Joe, your heart has already deteriorated—you are in bad shape. If we don't do something you are a goner. Fortunately, there are two possible ways we can save your life or at least buy you time. You can go with medication, which will save your life for sure although it will force you to restrict your activities. Or, you could go for a bypass, which will restore you to full health if it's successful but poses a small risk of killing you.

A doctor who wanted the patient to choose a bypass operation could frame the choices as prospective losses:

> Look Joe, I know you have lived a healthy, active life up to this point, but now you face an unpleasant choice. You can go with medication, which is completely safe, but will force you to cut back on your current activity level. Or, you can go with a bypass. The bypass poses a small risk of killing you, but if it is successful you won't have to give up anything and will maintain a healthy state.

Framing effects alone will certainly not determine anyone's choices. Joe's decision in the example just given will depend on many factors. But the sizable framing effects observed in Problems Three and Four, supported by many other studies, suggest that the way the choice is framed may have some influence on how the patient views it, and in a close case may make a difference in the outcome.

Conjunctive and disjunctive probability assessment. Informed consent disclosures often present a list of separate risks that a patient faces. A woman considering taking birth control pills, for example, may read a long list of possible serious side effects (breast cancer, bladder cancer, liver problems, heart disease, stroke) and a long list of less-serious side effects (depression, tenderness of breasts, fluid retention, weight gain, etc.). Sometimes the risk associated with each side effect (or with certain side effects) is quantified; other times there is only a rough indication of relative likelihoods. In any case, to reduce a list of separate risks into a commonsense estimate of how dangerous the treatment is as a whole may require the patient to combine the information about the various risks into composite estimates of the likelihood of danger. The patient may wonder about disjunctive probabilities—that is, about the likelihood that any one of several uncertain events will occur. Or the patient may wonder about conjunctive probabilities: the likelihood that each of several uncertain events will occur. The woman considering birth control pills, for example, may want to know the likelihood that anything really serious will happen as a result of taking the pill (a disjunctive probability). Or, she may wonder about the likelihood that some of the less serious effects will *all* occur (a conjunctive probability).

Considerable research shows that the estimates people make of disjunctive and conjunctive probability based on information about the likelihood of separate risks are often seriously in error as measured by the laws of probability.[38] People typically overestimate conjunctive probabilities and underestimate disjunctive ones. If a person learns the probability of event A is .2 and the probability of event B is .1, and knows the two events are independent, he or she will typically estimate the likelihood that both A and B will occur to be higher than .02 and will estimate the likelihood that one of the two will occur to be below .28. (The specified figures are the correct ones according to the laws of probability.) Estimates of this type are often wrong by a considerable degree. The woman evaluating birth control pills, then, is likely to underestimate the likelihood that something really serious will happen to her, and to overestimate the likelihood that several of the less-serious effects will all happen to her.

Interpreting Doctors' Linguistic Expressions of Probability. One additional difficulty patients face in assessing the risks and benefits of medical interventions is understanding the terms doctors use to convey estimates of likelihood. Doctors often fail to express risks in terms of numerical probability, preferring to use linguistic expressions. But are these linguistic terms intelligible to patients? When the doctor says a certain benefit is "likely" or "probable" or "expected," or that a certain procedure poses a "moderate risk," can the patient extract from those terms an accurate impression of the probabilities the doctor has in mind?

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[38] See Pitz, *supra* note 19.

A recent study indicated the problems of communicating likelihoods in linguistic terms by showing that doctors themselves ascribe widely different meanings to words typically used to define probability.[39] Sixteen doctors were asked to indicate the numerical probability they associate with 30 common words or expressions of probability. The doctors who conducted the study conclude that "the wide variation observed in the subjective probabilities is apparently due to consistently different interpretations of expression by individual physicians." They argue that doctors should use numerical probabilities in communicating with each other.

If doctors cannot understand each other when they use non-numerical terms of likelihood, we can hardly expect their patients to understand them. Furthermore, the wide range of meaning apparently entailed in each term leaves open the possibility that doctors can shade meanings in various ways in order to influence patients' choices without saying anything demonstrably incorrect.

Implications for Informed Consent

The possibility of "informed" consent. The research discussed above indicates that people may have difficulty drawing accurate conclusions about the risks they face on the basis of the information normally conveyed in informed consent disclosures. Does this imply that consent that is truly informed is impossible? Probably not. Difficulties in assessing risk exist, but these difficulties are probably not insurmountable, given adequate disclosures. Base rates, for example, are becoming better understood.[40] As the conditions under which people misuse base rates become well known, it should be possible to design disclosures that people will use appropriately. The other "errors" in judgment and inference people make may similarly be curable. Indeed, a great deal of current psychological research focuses on techniques for making human decisions more consistent with the dictates of normative models.[41]

Nevertheless, finding cures for the errors that plague human inference will not be a simple process. A number of commentators have suggested that the task of creating adequate disclosures is easy, a simple matter of common sense.[42] All one need do, they imply, is to give a straightforward, jargon-free explanation and accurate comprehension will follow. But as the research reviewed above indicates, simplicity in disclosures does not ensure accuracy of comprehension. People are quite likely to form inaccurate assessments of risk on the basis of simple, easy-to-understand disclosures. So it is not enough that patients understand what the doctor is telling them, they must also be able to draw appropriate inferences from it. It is quite possible for patients to "understand" a disclosure but misconstrue its import. Designing adequate disclosures, then, requires more than common sense; it requires an understanding of the way people process and use information.

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[39] Bryant and Norman, *Expressions of Probability: Words and Numbers*, 302 New Eng. J. Med. 441 (1980) (letter).

[40] Nisbett and Ross, *supra* note 16.

[41] *Id.*, at 273.

[42] E.g., Barber, *supra* note 2, at 78.

The need for empirical research. A close examination of the existing literature on decisionmaking could reveal a great deal about how to improve informed consent disclosures. But it is important to note the limitations of that literature as applied to the problem of informed consent. The research described above seems to identify basic limitations in people's ability to process information in a variety of contexts.[43] Nevertheless, generalizing the results of social scientific research to a new context is always problematic.[44] The only way to be sure of the extent of people's problems in drawing inferences from informed consent disclosures is to conduct empirical research in a medical context.

The issue of physician influence. The research discussed above suggests that despite the doctrine of informed consent doctors maintain considerable power to influence patients' decisions. Although the power to decide is nominally in the hands of patients, doctors remain the source (often the sole source) of information on which the decision is made. By manipulating the form and manner of disclosures doctors can influence people's perceptions of the risks and benefits of proposed interventions, and thereby influence their choices. This type of manipulation is not deterred by current liability rules, which predicate liability on the *content* of disclosures.[45] The problem is not that doctors disclose insufficient information or inaccurate information; the problem is that they may disclose accurate information in a way that causes patients to draw inaccurate conclusions.[46]

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[43] See *generally* Nisbett and Ross, *supra* note 15, and Slovic, Fischhoff, and Lichtenstein, *supra* note 16.

[44] See *generally* Argyle.

[45] The law in all 50 states requires doctors to disclose a certain amount of information to patients and subjects before obtaining their consent. Failure to disclose sufficient information may make the doctor liable to the patient either on a theory of battery (unconsented touching) or of negligence (breach of legal duty to patient). But with the exception of one or two states, see note 53 *infra*, the law does not specify the form or manner of disclosures. The doctor may make the disclosures on any manner he or she chooses so long as the requisite information is included. See *generally*, Annas, Glantz, and Katz, *supra* note 1. A disclosure that is blatantly misleading or unintelligible would, of course, be legally inadequate. Cobbs v. Grant, *supra* note 10.

Of course, it is not necessarily improper for doctors to influence patients' choices. It is important here to distinguish the *fact* of physician influence from the *manner* in which it is exercised. Few would object to a physician exerting influence over someone's decision by offering advice or moral guidance. But when the physician influences the person's choice by inducing a distorted perception of the risks and benefits of the alternatives, the influence is objectionable.

The distinction between proper and improper methods of influence might be clarified by considering where in the decision process the influence comes to bear. There should be no objection to the physician seeking to influence patients' choices at the second stage of the process—when someone is deciding whether undergoing the procedure is worthwhile according to their own values, given the risks and benefits presented—particularly when the patient asks for guidance.[47] With someone considering participation in a risky experiment, for example, a physician might discuss the societal value of medical research in general or the importance of altruism to the research enterprise. It would be objectionable, however, for the physician to try to influence the subject by exaggerating the importance or minimizing the risks of the study in which the subject is being asked to participate. Admittedly, the line between first-stage and second-stage influence is a fine one. In general, however, second-stage influence is akin to persuasion, while first-stage influence is more like deceit.

How can the law deal with doctors' ability to influence people's perceptions of risk and benefit? One possibility would be to work toward greater standardization of informed consent disclosures. If the disclosures doctors had to give for various procedures were specified in advance, doctors' ability to exert influence by varying the form and manner of disclosures would be reduced.

Disclosures to potential research subjects are already regulated, at least in part, by institutional review boards.[48] Although review boards are sometimes criticized for spending too much time "tinkering" with the language of consent forms,[49] the scrutiny they give the disclosures that are included in consent forms probably reduces the ability of physicians to mislead potential subjects about the risks and benefits they face. Of course, review boards have limitations. Because most boards do not have members who are familiar with research on decision-making and risk assessment it is possible that disclosures capable of misleading potential subjects might go undetected.[50] Providing information to review boards about the limitations on people's use of information would be helpful.

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[46] The inferential errors discussed above all occurred in response to factually accurate information.

[47] This sentiment may not be universally shared. As ethicists are quick to point out, physicians have no special expertise regarding decisions in the ethical moral domain. See Veatch, *Generalization of Expertise*, 1 (2) HASTINGS CTR. STUDIES 29 (1973).

[48] 45 CFR § 46 (1981).

A second problem of review boards is that their attention is directed primarily to the disclosures in consent forms. Until recently, review boards had no effective control over things the experimenter might tell the subject in order to "explain" or "elaborate" on the consent form.[51] New Federal rules[52] give review boards the authority to observe or have a third party observe the consent process. Exercising this authority might reduce physician influence. Unfortunately, the boards lack the personnel to undertake such observations in more than a few cases.

The experimenter's influence could be controlled most effectively by a limit on access to potential subjects before they consent to the experiment. But doing so would deprive potential subjects of an opportunity to question the experimenter and would be impractical in hospitals where doctors treat and conduct research on the same patients. Perhaps the best procedure would be to make initial disclosures to potential subjects in writing only (on forms reviewed by the institutional review board), and to allow experimenters to discuss participation directly with potential experimental subjects only if they indicate an interest in the study after reading the initial disclosures.

There are no review boards to regulate doctors' disclosures to patients about possible treatments. Hence the doctor-patient relationship is one in which doctors are relatively unfettered in their ability to influence patients' assessments of treatment options through manipulating the form and manner of disclosures. A few states have moved toward legislative specification of the form of disclosures,[53] raising the possibility that treatment disclosures may someday be standardized. The Ohio legislature has set forth a model consent form in its statute and provided that consent will be presumed valid if the form is used.[54] Colorado for a time required that physicians express the likelihood of various risks in terms of probabilities.[55] Although the purported goal of standardization is to ensure that patients actually receive the information the legislature thinks they should have, standardization probably has the additional benefit of reducing physicians' ability to manipulate patients' perception of risk.

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[49] Treat, *Proposed Changes for Obtaining Informed Consent from Experimental Subjects*, 1 LAW AND HUM. BEH. 403 (1977).

[50] IRB members unfamiliar with people's misuse of base rates, for example, might find disclosures similar to those given in the tumor example above to be perfectly adequate when in fact they are likely to be quite misleading.

[51] The old Federal rules did not give review boards the authority to observe the consent process.

[52] 46 Fed. Reg. 8386 (1981).

Nothing is known as yet about how accurately people can assess the risks of a treatment on the basis of the legislatively mandated disclosures. It is to be hoped that research on what type of disclosure form is best will be done soon and that such studies will be used by legislators in formulating future disclosure standards.

Critics have argued that standardizing disclosures may interfere with the process of informed consent by reducing it to a formality and making a meaningful dialogue between physician and patient less likely to occur.[56] There is also a danger that standardized forms will become too inflexible. These possible disadvantages must, of course, be weighed against the potential benefits of standardization.

As with disclosure forms for experimental research, standardizing therapeutic disclosures will not limit doctors' ability to influence patients' evaluations by providing additional information or by "explaining" the standardized disclosures. To the extent this is a problem, there seems no good way to solve it.

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[53] A Texas statute, for example, creates a Medical Disclosure Panel composed of physicians and attorneys that is charged with determining and listing medical treatments that do and do not require disclosure of risks and hazards. For treatments requiring disclosure, the panel "shall establish the degree of disclosure required and *the form in which the disclosure will be made*" (emphasis added). 1977 Texas Sess. Law Serv. Ch. 817 §§ 6.03-6.07, §§ 6.04(b).

[54] Ohio Rev. Code Ann. § 2317.54(A) (1976), as amended Am. H.B. No. 213, effective Nov. 24, 1977. Several other states also provide that a signed consent form meeting certain specified conditions creates a presumption that consent was validly obtained. [See, e.g., Fla. Stat. Ann § 768.46(a)]. But they do not provide a model form like Ohio's.

[55] Colo. Rev. Stats. § 13-20-30 1976, repealed H.B. No. 1106, May 27, 1977, required physicians to quantify such risks by stating, "the percentage within two percent of the risk associated with the procedure, which percentage is either contained in a recognized medical publication or is measured by the experience of the physician out of a substantial number of the same or similar procedures." [§ 13-20-302(2).] Ludlam, *supra* note 9, at 49, suggests this law was repealed because the requirement that risks be disclosed with such exactitude proved unworkable in practice.

[56] Annas, Glantz, and Katz, *supra* note 1, at 41, 42.

The scope of disclosures: More is not necessarily better. The current law of informed consent is intended to force doctors to disclose sufficient information to allow an informed choice. The primary concern underlying the law is that patients will misperceive the risks and benefits they face because doctors tell them too little. The research reviewed above raises a different concern—that people will misperceive the risks and benefits they face because doctors tell them too much. The problem is not simply the oft-expressed concern that patients will be confused by technical details. Indeed, the research suggests that the information that is most detrimental to accurate understanding is often that which is easy to understand because it is vivid, striking, and memorable. The problem is that people's assessments of risk and benefits are influenced by facts that normatively and logically should not have an influence. People give disproportionate weight to certain types of information. Consequently an "accurate" disclosure can produce an inaccurate understanding.

This point has important implications for the goals of informed consent: protecting people's autonomy and their welfare. Patients' autonomy is arguably only protected if they are given all the information that would make a difference to their decisions. But if certain pieces of information make a difference when normatively they should not, disclosing such information may preserve people's autonomy at the cost of giving them an inaccurate picture of the risks and benefits they face. In other words, preserving people's autonomy might require sacrificing their welfare, and vice versa.

As an illustration of the trade-off between autonomy and accuracy, consider a situation similar to the notorious experiment conducted in the Jewish Chronic Disease Hospital in Brooklyn, in which experimenters injected live cancer cells subcutaneously into patients as part of a study of people's ability to reject foreign cells.[57] For argument's sake, let us assume that the injections pose no risk to subjects but that learning the injections contain cancer will cause subjects to greatly overestimate the dangers posed by the experiment.[58] Under such circumstances should potential subjects be told the injections contain cancer cells? This disclosure is one that will make a difference to the decision of many subjects, hence disclosure is essential to protecting their autonomy. But the disclosure protects their autonomy at the price of their objectivity. Subjects' assessments of the risks of physical injury posed by the experiment will be more accurate if they are not told about the cancer.

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[57] See Hyman v. Jewish Chronic Disease Hospital, 42 Misc. 2d. 427, 248 N.Y.S. 2d 245 (Sup. Ct. 1964); *See also* Katz, EXPERIMENTATION WITH HUMAN BEINGS (1972) at 9-65.

[58] This may not have been true in the actual Chronic Disease Hospital case, but let us assume it is true for purposes of the present discussion.

In a case like this, most people would probably feel that protecting subjects' autonomy is more important than ensuring they assess accurately the risks and benefits they face. But it is possible to imagine cases where accurate risk assessment would be seen as more important than autonomy. Suppose, for example, that an experimenter wishes to recruit cancer patients for a dangerous experiment in which they will be injected with a substance that has no therapeutic value. Suppose further that if subjects learn the name of the substance they will mistakenly believe it to be therapeutic. (This might occur if, for example, the name of the substance sounded like laetrile.) Should the experimenter disclose the name of the substance? This disclosure will make a difference to subjects' decisions about whether to participate, hence the disclosure will protect their autonomy. But once again the disclosure protects their autonomy at the expense of their objectivity. In this case "protecting" subjects' autonomy may result in their participating in a dangerous experiment—one that they would have refused had they not been misled about its possible benefits by "full" disclosure.

These two examples illustrate that more disclosure is not necessarily better. In this light, the law's current trend toward greater disclosure requirements may be viewed as a mixed blessing. Care must be taken that, in striving to protect people's autonomy, the law not require doctors to disclose facts that will mislead them into making nonoptimal decisions. As Annas, Glantz, and Katz note in their book on informed consent, the goal of encouraging rational decisonmaking, while viewed by the courts as secondary to preserving autonomy, "is, in fact, an extremely important function of the informed consent doctrine at least to the extent that if this goal was not achieved in any instance, the entire concept would be called into serious question."[59]

Limitations on Patients' Ability to Exercise Free Choice

The Malleability of Human Behavior and Choice. Social psychologists have studied social influences on behavior for years. Their general approach has been to observe people's behavior while experimentally varying (some would say manipulating) the situations in which people find themselves. Thousands of experiments have examined the situational determinants of behaviors, ranging from altruism to aggression and from affiliation to micturation.[60] Perhaps the primary conclusion that can be drawn from this literature is that behavior is remarkably malleable. Situations can be constructed so as to induce people to do or not to do an amazing number of things.

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[59] Annas, Glantz, and Katz, *supra* note 1, at 36.

One classical experiment that illustrates the power of situational forces on behavior was reported by Asch in 1955.[61] In what was purportedly a study of visual discrimination, subjects were asked to perform a task judging the relative lengths of lines. With the subject were several other people who appeared to be fellow participants but who were actually confederates of the experimenter. The goal of the experiment was to see if subjects could be induced by social pressure to give incorrect answers on the line discrimination task. Asch found that subjects could indeed be induced to give answers that were obviously wrong. When the confederates all gave a wrong answer on the task, most of the subjects went along. Even more dramatic were the results of experiments reported by Milgram in 1963.[62] In what were purportedly experiments on the effects of reinforcement on learning, a substantial proportion of subjects were induced by an insistent experimenter to give what they believed to be dangerous electrical shocks to another person.

The social psychological literature has important implications for the law of informed consent. In making legal rules, care must be taken that "consent" is not obtained in situations that constrain patients' freedom of choice. Because constraints on choice are often quite subtle, the social psychological influences in the consent situation must be examined.

Inducing Compliance: Some Classical Findings

Compliance without pressure: The foot-in-the-door technique. An interesting finding was first reported by Freedman and Fraser in 1966 and has since been replicated by many researchers.[63] They found that inducing a person to comply with a small initial request substantially increased compliance with a subsequent larger request. This phenomenon was dubbed the foot-in-the-door effect. The initial experiment tested the willingness of housewives to cooperate with a purported consumer survey organization. Those who complied with an initial small request (to answer eight innocuous questions in a telephone survey) were subsequently significantly more likely (than a control group not contacted by the consumer organization) to agree to allow five or six men in their house to spend several hours going through cupboards and storage spaces and classifying all the consumer products they found. Among the housewives who complied with the initial request, 53% agreed to the subsequent large request, compared with 22% of the housewives who were not contacted initially.

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[60] *See generally* Middlebrook, SOCIAL PSYCHOLOGY AND MODERN LIFE (1974).

[61] Asch, *Opinions and Social Pressure* 193 SCI. AM. 31 (1955).

[62] Milgram, *Behavioral Study of Obedience*, J. ABN. AND SOC. PSYCH 371 (1963).

[63] Freedman and Fraser, *Compliance Without Pressure: The Foot-In-The-Door Technique*, 4 J. PERS. AND SOC. PSYCH. 195 (1966).

The foot-in-the-door effect has since been replicated in a variety of contexts. The general finding is that the more small acts of compliance the experimenter obtains before asking for a target decision, the higher the compliance rate for the target request. In a study of determinants of the decision to donate bone marrow, for example, Schwartz found that obtaining small acts of compliance (coming to the interviewer's table at a blood donation center, allowing already donated blood to be tested, giving an additional sample, etc.) before asking for the bone marrow donation dramatically increased the proportion of people who donated.[64]

The foot-in-the-door technique could obviously be used by physician-experimenters looking for subjects for medical experiments. Indeed, a social psychologist, Saks, has noted some troubling similarities between the foot-in-the-door technique and procedures currently used to solicit kidney donors.[65]

> The policy of . . . transplant teams around the country (is) to delay until the end of the selection process actually asking a prospective donor to make the decision to be or not to be a donor. First, prospective donors would be asked to submit to a series of examinations, tests and briefings. Only after a person had an opportunity to understand the purposes, procedures and risks of the donation, was found to be in good health, and was found to be compatible would the request for a decision and commitment be made.[66]

Saks points out that "whatever its 'moral' merits, the procedure probably also increase(s) the proportion of persons who would consent to donate."[67]

Guilt, negative mood states, and compliance. Another way to increase a person's compliance is to make him or her feel guilty. In a series of studies on compliance, Freedman, Wallington, and Bless contrived situations in which their experimental subjects were induced to perform some negative behavior (such as lying or knocking a sequenced stack of note cards off a table).[68] Subjects were subsequently asked if they would take part in another experiment. People who had been involved in the guilt-inducing event were considerably more likely (than those who were not) to agree to this request. Freedman et *al.* interpreted the result as an attempt by subjects to expiate guilt by doing something good ("volunteering" to be in an experiment again).

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[64] Schwartz, *Elicitation of Moral Obligation and Self-Sacrificing Behavior: An Experimental Study of Volunteering to be A Bone Marrow Donor,* 15 J. PERS AND SOC. PSYCH 283 (1970).

[65] Saks, *Social Psychological Contributions to a Legislative Subcommittee on Organ and Tissue Transplants,* AM. PSYCH. 680, 684 (July 1978).

[66] *Id.*, at 684.

[67] *Id.*

Subsequent research on this phenomenon has shown that the "guilt-expiation" effect is part of a more general tendency for people experiencing negative emotional states to show increased compliance, especially to requests to do good acts.[69] This effect is apparently caused by people's efforts to make themselves feel better by doing good deeds, thus proving to others, or to themselves, that they are worthwhile individuals.[70] Although the effect is not found for people whose negative feelings are focused solely on their own self-concerns,[71] negative feelings occasioned by events in the outside world reliably produce the effect. Making a person believe he has committed a transgression is a particularly effective technique for inducing negative feelings that eventuate in an urge to help.[72]

Patients who are hospitalized seem particularly vulnerable to manipulation via subtle events affecting their moods. Placed in a role of powerful guardian and protector of patients, doctors probably have considerable power to make patients feel that they have done something wrong or that they are not worthwhile people. Feelings of this sort are likely to make patients willing, perhaps even eager, to do something "good." In this state they are far more likely than normal to volunteer for an experiment. This tendency is probably most likely in patients who are recovering or are habituated to their condition. As noted above, the "feel bad, do good" effect is not found among people preoccupied with their own problems. Such people are unlikely to comply with a request to help under any circumstance.

Reciprocity and compliance. Doing someone a small favor also increases a person's compliance. A number of experiments reveal that acts of kindness of various sorts (such as buying people sodas or helping them on tests) make the beneficiary more likely to comply with a subsequent request.[73] The effect is strongest if the subsequent request is made by the person who did the favor, but beneficiaries are also more compliant to requests from other people, particularly if the person making the request is somehow related to the person who did the favor. This effect is usually attributed to strong norms of reciprocity that exist in our society. People believe a favor deserves a favor and that there is a social obligation to help those who helped them.

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[68] Freedman, Wallington, and Bless, *Compliance Without Pressure: The Effect of Guilt*, 7 J. PERS AND SOC. PSYCH 117 (1967).

[69] Cialdini, Darby, and Vincent, *Transgression and Altruism: A Case for Hedonism*, 9 J. EXPERIMENTAL PSYCH. 502 (1973).

[70] Id.

[71] Thompson, Cowan, and Rosenhan, *Focus of Attention Mediates the Impact of Negative Affect on Altruism*, 38 J. PERS. AND SOC. PSYCH. 291 (1980).

[72] Cialdini, Darby, and Vincent, *supra* note 74.

[73] Isen and Levin, *The Effect of Feeling Good on Helping: Cookies and Kindness*, 21 J. PERS. AND SOC. PSYCH. 384 (1972).

Again, hospitalized patients seem particularly vulnerable to this effect. It would be difficult for a patient not to feel a sense of gratitude to the doctors who sustain his life—indeed most would argue the patient *should* be grateful. Doctors, however, can play on the gratitude of patients in order to increase their compliance.

Malleability of Behavior—Actual and Perceived. The studies described above are but a few examples that document the malleability of human behavior. The findings in this literature are interesting in part because they are surprising. One would not expect that a small prior request would increase compliance rates from 17 to 76%,[74] and yet effects of this magnitude are not uncommon.[75] Recently the "surprisingness" of social psychological findings has itself been the focus of psychological inquiry. Ross[76] has pointed out that the capacity of such findings to surprise us reveals something interesting about people's understanding of the determinants of human behavior. We are suprised, Ross argues, because we hold misconceptions about what makes us behave as we do. Specifically, we disproportionately attribute the behavior of others to internal causes, i.e., motives, intentions, personalities, etc.; but we underestimate the influence of external causes, i.e. situational and social pressure. Hence, when social psychologists prove that behavior can be strongly influenced by external factors we are suprised. Ross labels this basic tendency of overattributing behavior to internal causes while underattributing it to external causes the "fundamental attribution error." The error is "fundamental" because it appears to arise in a variety of contexts. An important consequence of this phenomenon is that people often fail to recognize coercive pressure when they see it. We tend to assume people's behavior is self-motivated even when it occurs in response to powerful external pressures.

This effect was demonstrated in a study by Bierbrauer.[77] He was curious about people's ability to appreciate the power of external influences on subjects in one of psychology's most coercive studies, the Milgram experiment.[78] In Milgram's study an "authority figure," the lab-coated experimenter, was able to induce subjects to give what they thought were dangerous (and even fatal) electrical shocks to another person. Bierbrauer was curious to know whether people unfamiliar with Milgram's results realize how effectively the authority figure can induce compliance. Of course, the fact that Milgram's findings are so surprising is one indication that people underestimate the influence of authority figures (or, alternatively, overestimate people's capacity to resist such influence). But these underestimates may result from unfamiliarity with the details of the situation Milgram created in his experiment.

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[74] See note 63 *supra* and accompanying text.

[75] Keisler and Keisler, CONFORMITY (1969).

[76] Ross, *The Intuitive Psychologist and His Shortcomings*, in Berkowitz (ed.) ADVANCES IN EXPERIMENTAL SOCIAL PSYCHOLOGY (1977).

[77] Bierbrauer, *Effect of Set, Perspective, and Temporal Factors in Attribution*, unpublished doctoral dissertation, Stanford University (1973).

To rule out this possibility Bierbrauer conducted a study in which he gave people detailed information about the techniques of the Milgram experiment, including exposure to the equipment and mock run-throughs of the experimental procedure, and then asked them how effective they thought the external pressures would be in inducing compliance. (Bierbrauer's subjects were all unaware of the actual results of the Milgram experiment.) Even when familiarized with the procedures, people still dramatically underestimated the percentage of subjects in a Milgram situation who would comply with the experimenter's request to administer electrical shocks. This underestimate of the external pressures operating in the experiment was coupled with an apparent tendency to assume people who complied with the request (to administer shocks) did so due to internal (dispositional) factors rather than due to external pressure.

The failure of Bierbrauer's subjects to appreciate the power of external pressures in the Milgram experiment raises doubts about the ability of outsiders to appreciate the power external pressures bring to bear on patients in medical settings. Observers monitoring the consent process may be able to detect blatant forms of pressure. But they may be unable to detect the more subtle pressures discussed in this paper. Consequently, a person observing the consent process may believe subjects are consenting freely when in fact the situation makes it very difficult for them not to consent.

Implications for Informed Consent

Autonomy. Preserving patients' autonomy is a fundamental goal of informed consent. Do the findings cited above cast doubt on the ability of current informed consent procedures to protect that autonomy?

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[78] Milgram, Obedience to Authority (1974).

This question raises difficult philosophical issues about the nature of autonomy. The research suggests that people's decisions to consent can be influenced by situational/external pressures. But, with the possible exception of the Milgram experiment, the influence shown is not of a sort that would deprive a person's consent of its *legal* effect.[79] There is no duress, no "overbearing of will." By legal standards, the housewives' choices to allow a team of men to tramp through their house examining consumer products were freely made. So were the decisions of subjects in the other "compliance" studies. Nevertheless, it is troubling that these "free" decisions can be so strongly influenced by other people. I have argued that in medical settings doctors are in a position to wield a great deal of influence over patients' decisions through various social psychological ploys. This type of influence would not be considered coercive, but is there any principled way to distinguish the influence a doctor might wield through clever use of social psychological techniques (like the foot-in-the-door effect) from the influence the doctor might exercise through outright coercion?

Consider the following hypothetical situation. Researchers A, B, and C are having difficulty recruiting hospitalized patients to participate in experiments. Each finds that standard recruitment techniques result in consent by only 5% of patients solicited in their respective hospitals. In order to increase the rate of volunteering, A threatens to have patients in his hospital removed to a less desirable ward unless they consent to be experimental subjects. This threat increases the volunteer rate to 25%. B and C, who have studied social psychology, adopt more subtle methods. B seeks to increase volunteering by doing small favors for potential subjects prior to making his pitch; C, before he makes his pitch, has a colleague criticize potential subjects for having committed small transgressions of hospital rules (in order to make them feel guilty). B and C find that their ploys also increase their respective rates of volunteering to 25%. In all three cases, an action by the experimenter increased the rate of volunteering. If these subjects who "volunteered" in response to the experimenter's ploys would not otherwise have volunteered, were their decisions to consent autonomous?

Commentators have extensively criticized procedures such as those employed by A.[80] Inducing consent by threats has justifiably been condemned. But are the procedures used by B and C really any different from the threats used by A? The *effect* is the same in each case. The *intent* of the researchers, to increase compliance, was also the same in each case. One way to distinguish the procedures is to look to the feelings of the subjects. A's subjects are likely to have felt coerced, B's and C's are not. Thus A's ploy destroyed a subject's subjective feeling of autonomy while B's and C's maintained it. But is this distinction really important? When we seek to protect patients' autonomy do we really mean just their perception of autonomy? The three ploys were equally effective. Hence the greater feeling of autonomy of B's and C's subjects is, arguably, illusory. Is the illusion of freedom what is really important?

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[79] *See generally*, 25 Am. Jur. 2d 351.

[80] Barber, *supra* note 2.

Another distinction might be drawn based on the propriety of the researcher's actions.[81] The actions of A and C might be seen as somehow inappropriate or improper for a doctor. Doctors are not supposed to threaten patients or to criticize them for ulterior purposes. Doctors are, however, supposed to be nice to patients. The increased compliance of B's patients, then, might be seen as an incidental effect of a behavior doctors have a right to engage in, and thus to be acceptable. Since A and C had no "right" to do what they did the resulting effect might be labeled coercive. This distinction is at least analogous to existing legal rules regarding coercion in other contexts.[82] Nevertheless, a rule holding that doctors may intentionally manipulate patient's decisions so long as they do so through doctor-like actions seems inconsistent with the goal that motivated concern with informed consent: placing decisionmaking control in the hands of the patients rather than doctors.

Welfare. A second major goal of informed consent is to preserve patients' welfare by ensuring that the decisions made are in their best interest as they define it. Do the social psychological findings discussed above cast doubt on the ability of current informed consent procedures to protect patients' welfare?

In theory, informed consent protects patients' welfare by alowing them, rather than the doctor, to make the ultimate decision.[83] Placing the decision in the hands of patients ensures it will accord with the patient's own values. But the existence of this theoretical advantage is predicated on the existence of free choice by patients. If the patient is merely a nominal decisionmaker who responds like a puppet while the doctor pulls the strings, the decision will not necessarily accord with the patient's values.

The crucial issue, then, is how much influence doctors can exert over patients' decisions through psychological ploys.[84] The research suggest doctors' influence may be fairly powerful—but it is unclear how well these findings generalize to medical settings. It is possible that subtle ploys by doctors will have little influence where important consequences are at stake and patients have a clear preference for one choice over another. But the social psychological effects do not appear limited to situations where the decisions have trivial consequences. The foot-in-the-door technique, for example, had strong effects on people's decisions to donate bone marrow or allow a team of men to spend several hours ransacking their cupboards—decisions with varying levels of consequences. Whether social psychological effects will be strong when patients have a clear preference for one choice over another is less certain. The powerful results discussed above may have occurred only because subjects felt no clear preference prior to being manipulated into choosing one alternative over the other. Hence doctors may be able to induce patients to make a particular choice only when the patient is uncertain about what to do or confused by the alternatives. This level of influence may pose a real danger, however, when subtle pressure exerted during an initial period of ambivalence may cause patients to commit themselves to a nonoptimal course of action that they would not have chosen had they been left to struggle with the choice in the absence of pressure.

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[81] This distinction parallels that drawn by the law of duress between wrongful and nonwrongful acts. It is generally held that an act must be wrongful to constitute duress. 25 AM. JUR. 2d 351, 356.

[82] Id. *See also* Fowler v. Mamford, 48 Del. 282, 102 A.2d 353.

[83] See note 5 *supra* and accompanying text.

[84] It is important to note, once again, that doctors' ability to influence patients' decisions is not objectionable per se. Few would object to

The Inadequacy of Current Law. Current law is inadequate to protect patients from the sorts of subtle psychological influences discussed. Although blatant forms of duress and coercion would invalidate consent under state law[85] and would violate Federal regulations,[86] subtle forms of coercion are likely to be unreachable by the law.

Consider the difficulty faced by a patient who seeks to recover damages from a doctor who subtly manipulated him into consenting to a procedure that resulted in injury. In states that predicate liability on a battery theory[87] the patient/plaintiff

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doctors' influencing patients by giving advice and recommendations, or even by arguing forcefully in favor of a particular choice. What is objectionable about the psychological ploys is not the fact that they influence patient-subjects' decisions but the way in which they influence them. To argue with a person and seek to persuade him or her is to respect the person's autonomy. To subtly coerce a person into following your desires is to undermine that person's ability to make decisions that are in his or her best interest as the person sees it.

[85] See, e.g., Cobbs v. Grant, *supra* note 10.

[86] 45 CFR § 46.103(c).

[87] Some states permit an action for lack of proper informed consent to be brought under a theory of battery (unconsented touching). See Ludlam *supra* note 9, at 23. If the plaintiff shows that consent was invalid, the medical intervention is held to be a battery and the doctor is liable for any adverse consequences of it.

would probably be required to show that his consent was obtained under duress[88] for which the legal standards are very stringent.[89]

In states that predicate liability on a negligence theory[90] the patient would be required to show that the doctor's manipulative actions were a breach of the doctor's duty to him. But in determining whether the doctor breached his duty the court would probably apply a "professional standard." In other words, the scope of the doctor's duty would be determined by the standards of behavior of the medical profession.[91] This would impose on the plaintiff the burden of proving the nature of customary professional practice (which typically requires expert medical testimony) as well as the burden of proving that his doctor departed from that practice. Since doctors can accomplish manipulative ends through actions that are entirely appropriate,[92] the plaintiff might have difficulty showing any breach of professional standards. Even if the plaintiff could show a breach of the doctor's duty, it would be difficult to prove a causal connection between that breach and the injury. The patient would need to establish that "but for" the doctor's wrongful actions he would not have consented to the procedure and therefore would not have been injured.[93]

In deciding whether the doctor's wrongful actions *caused* the patient's injury (in the "but-for" sense) the jury would be evaluating how influential the doctor's actions had been. Since jurors are likely to be victims of the fundamental attribution error[94] they would tend to underestimate the influence of the doctor's actions and overestimate the degree to which the patient exercised free choice. Hence, it would be hard to convince the jurors of the existence of a causal connection even where one did, in fact, exist. In sum, the patient/plaintiff's prospects for a favorable verdict would be dim.

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[88] Consent is a complete defense to battery unless the consent is invalid or exceeded. R.S. Torts § 18 (b). If the doctor could show the patient "consented" by signing a consent form or otherwise assenting, the burden of proving the consent invalid would shift to the patient. Indeed, statutes in some states specify that a signed consent form creates a presumption that the consent was valid. Ludlam, *supra* note 9, at 42.

[89] 25 Am. Jur. 2d 351.

[90] The modern trend among states is to require actions for lack of proper informed consent to be brought under a theory of negligence. In these states the law imposes a duty on doctors to obtain proper informed consent. Cobbs v. Grant, *supra* note 10. To prevail under a negligence theory a plaintiff must show that the doctor had a duty toward the patient (to gain proper consent) that was breached, and that the patient was injured *as a result* of the breach. *Id.*

[91] See Ludlam, *supra* note 9, at 26.

[92] *See* note 82 *supra* and accompanying text.

[93] For a discussion of the requirement of causality in an informed consent case, see Cobbs v. Grant, *supra* note 10.

[94] *See* note 76 *supra* and accompanying text.

Some of the same problems arise in seeking to prove that a researcher's manipulative actions violated Federal regulations. Current regulations require subjects who consent to participation in research be "so situated as to be able to exercise free power of choice without undue inducement or any element of force, fraud, deceit, duress or other form of constraint or coercion."[95] The framers of the regulations apparently assumed that whether or not subjects are able to "exercise free power of choice" in a given situation is a question that can be answered easily. Yet research on the fundamental attribution error casts considerable doubt on this assumption. Coercive situations are not always recognized as such. Consequently, the current Federal regulations may fail to affect subtle manipulative actions.[96]

Reducing patients' susceptibility to external pressure. How might the law be changed in order to reduce patients' susceptibility to external pressure? One approach would be to forbid doctors, when practical, from acting in ways likely to undermine patients' autonomy. State law could impose on doctors a duty not to behave in certain ways and Federal regulations could specify improper behaviors. Whether rules could be developed that increase patients' autonomy without hindering the legitimate activities of doctors is a question worthy of discussion (but beyond the scope of this paper). Such a discussion would necessarily begin with a comprehensive review of empirical research on the possibility of coercion. This paper examined enough research to show that subtle coercive pressures exist, but not enough to show all the ways they might exist. After identifying actions having a coercive effect that doctors might engage in, the inquiry could shift to a consideration of the practicality of regulating those actions. A few suggestions on what the law might ultimately require follow.

Timing of disclosures. One important factor to consider is the timing of disclosures and of the patient's decision to consent. In many cases disclosure and consent are delayed past the point at which a patient has become psychologically committed to going through with an intervention. The kidney donor has already taken a number of psychologically important steps toward donation before the final request to donate is made. Surgical patients are often already checked-in to the hospital where they will have their operation before receiving full disclosures on the risks of anesthesia. Backing out of an operation at that point would be a financial as well as a psychological embarrassment. Hence, disclosures at that point do little to assure patients' autonomy. A better approach would be to disclose information as early as possible in order to allow patients to make decisions before the decisions have, in effect, been made for them.

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[95] 45 CFR § 46.103(c).

[96] Under Federal regulations the institutional review board acts as the policing body. If members of the board are unable to recognize coercive pressures as such, they will not be able to eliminate them.

Perhaps the law could impose on doctors a duty to make disclosures 24 hours before patients are required to make a decision or to take any action that would commit them to a decision. (Exceptions could, of course, be made for emergency procedures.)

The physician-patient relationship. Another factor, one that is particularly important in the experimental context, is the physician/experimenter's relationship with the patient or experimental subject. Social psychological research suggests that hospitalized patients may be particularly vulnerable to (intentional or unintentional) manipulation by experimenters eager to convince them to participate. One way to control this manipulation is to limit experimenters' access to potential subjects. Perhaps the law should impose a duty on physician-experimenters to solicit subjects through a disinterested intermediary when dealing with groups particularly susceptible to influence (such as hospitalized patients).

Conclusion

Relying on psychological research, this article has identified two major limitations of the law of informed consent. First, the law fails to ensure that information is disclosed to patients in a way that enables them to assess accurately the risks they face. The law leaves control over the form and manner of disclosures largely in the hands of physicians, who may inadvertantly (or intentionally) present the information in a manner that promotes erroneous inferences and conclusions. Second, the law fails to protect patients from subtle forms of psychological pressure that, although often difficult to detect, are surprisingly powerful and may be indistinguishable conceptually from blatant forms of coercion.

The psychological research discussed here dispels the notion that physicians can adequately "inform" patients simply by presenting the required information to them in a simple, jargon-free manner. As the studies reviewed earlier indicate, people often draw strikingly inaccurate conclusions about the risks they face on the basis of relatively simple information that is much like the information patients must evaluate in making important medical decisions. These studies suggest that subtle biases in the way people process and use information must be taken into account by those who seek to "inform" patients of risks. Further empirical research is needed to determine the best way to avoid these biases and to ensure that patients draw accurate conclusions about risks.

Psychological research also suggests that, despite the laws of informed consent, physicians hold the power to exert a manipulative influence over patients' decisions. Physicians may manipulate these decisions by framing or couching disclosures in a way that causes the patients to draw inaccurate conclusions about risks, or by using psychological ploys that influence the patients' willingness to consent. This sort of manipulation undermines patients' autonomy and, arguably, their welfare as well, but there is little the law can do to prevent it. The ability of physicians to influence patients improperly might be reduced through standardizing disclosures, limiting experimenters' access to potential subjects who have not yet consented, and monitoring the procedures physicians follow when seeking consent. Unfortunately, each of these measures has serious drawbacks. As a practical matter, the problem of the manipulative physician, to the extent it is a problem, may be beyond the reach of the law.

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Medical Education and Physician-Patient Communication

Caroline L. Kaufmann, Ph.D.*

Introduction

The organization of medical education has undergone rapid and dramatic change over the last two decades. One major thrust of that change has been to increase the relevance of the educational experience to medical practice. While considerable differences exist among educators as to what is or is not relevant, one point is clear: student physicians require training in communicating effectively with patients. Concern with the communicative skills of student physicians is well represented in training programs in comprehensive and family medicine, as well as in more specialized training in psychiatry and behavioral medicine. Educators have made concerted efforts to integrate formal course work and clinical experiences specifically addressed to the care of the whole patient into the more traditionally science-oriented components of graduate medical education.

In examining the issue of physician-patient communication in medical treatment, numerous studies have documented the fact that physicians tend to provide very little information to a patient about his or her illness, its treatment, and the associated risks, benefits, and alternatives.[1,2,3] Several recent studies have demonstrated that the patients desire open and informative communication with their physicians.[4,5] The persistence of noninformative communication from physicians despite latent and expressed desire for such among patients suggests that physicians are not meeting the informational needs of patients in the treatment process. The reasons for the failure to communicate adequately with patients are many. The present analysis will examine several of the more noticeable factors in physicians' resistance to open and informative communication with patients.

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[1] Innes, J.M. *Does the professional know what the client wants?* Social Science and Medicine, *11* (11-13), 635-638 (1977).

[2] Haug, M.R. and Lavin, B. *Practitioner or patient—who's in charge.* Journal of Health and Social Behavior, *22* (3), 212-228 (1981).

[3] Hulka, B.S., Zyzanski, J., Casell, J.C., and Thompson, S.J. *Satisfaction*

The report summarizes the major trends in graduate medical education that focus on developing the communicative skills of physicians. In designing this analysis, particular attention is given to procedures for selecting candidates for medical school, as well as to the organization and content of the educational experiences after admission. Criteria for selecting students are examined to determine whether the selection criteria favor a student who is predisposed to developing non-communicative, authoritarian relationships with patients. The organization and content of the educational experience are examined to reveal whether the process is itself one that trains students in the art of poor communication with patients.

In rudimentary form, this analysis is a variation of the "nature vs. nurture" argument. If poor communication skills result from the types of applicants who are admitted—persons who by nature are socially and psychologically predisposed to noncommunicative behavior—then simply changing admission criteria to favor a different type of applicant may result in a significant change in the behavior of new generations of physicians. In contrast, if the organization and content of medical education nurture noncommunicative behavior among students, then change in the educational process will be more effective in promoting open communication with patients among young physicians. Both selection criteria for admission to medical school and the organization and content of medical education have been subjected to empirical evaluation. This report will attempt to pull together what is already known about each and what value they might have in producing behavior and attitudinal change. The purpose of this analysis is to provide basic information useful in making recommendations

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with medical care in a low income population. Journal of Chronic Diseases (24), 661 (1971).

[4] Roter, D.L. *Patient participation in the patient-provider interactions: The effects of patient question asking on the quality of interaction satisfaction and compliance.* Health Education Monographs, 5 (4), 281-315 (1977).

[5] Stimson, G.V. and Webb, B. Going to See the Doctor: The Consultation Process in General Practice. Boston: Routledge and Kegan Paul, 1975.

for change in the process of medical education in order to assure that student physicians are provided with educational experiences that promote open, effective, and informative communication with patients.

Criteria for Medical School Admission—A Need for Reexamination

A number of reform-minded critics of medical education have suggested that the selection process favors applicants with specific social, psychological, and biological characteristics. These characteristics are viewed as being associated with specific behavioral traits, resulting in a selective bias in the behavior of medical practitioners. According to this view, dramatic change in the behavior of physicians could be realized within a relatively short period of time simply by admitting more women, blacks, and ethnic minorities into U.S. medical schools. This line of reasoning derives from an assumption that social class, gender, or ethnic background is a stronger determinant of attitudes and behavior among medical students than is the training and professional socialization they receive in their formal academic careers.

Recent analyses of application and enrollment in U.S. medical schools over roughly a ten-year period have shown that women and ethnic minorities, historically underrepresented in the medical profession, have been admitted to medical school in increasing numbers. Application and enrollment figures show a 27% increase in total female enrollment from 1974 to 1980. Women made up 27.8% of the 1979-80 first-year medical school class.[6] Enrollment by racial and ethnic minorities constituted 8% of the total medical school enrollment. In short, the gender, racial, and ethnic characteristics of the population of medical students are becoming slightly less dominated by white, middle-class males.[7]

The social class and background characteristics of females and ethnic minorities show some differences between them and their white male colleagues. Data from the 1976-77 enrollment shows that 50% of white students compared to 18% of blacks came from households in which the parents' income was $20,000 or more. White students more often had fathers with professional or managerial occupations. In addition, 14% of white students had fathers who were physicians, compared to 7% of black students. Of the Hispanic and American Indian students, 20% came from households with parental income of $20,000 or more and 11% had fathers who were physicians.[8] There is no evidence of social class differences between white males and females. These findings indicate that minority medical students, while better-off compared to their own ethnic groups, are less likely than their white counterparts to have high-status backgrounds.

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[6] Thomas-Forgues, M. and Tonesk, X. *1979-80 enrollment in U.S. medical schools*. JOURNAL OF MEDICAL EDUCATION, 55 (12), 1042-1044 (1980).

[7] *Ibid.*

Differences between male and female students have been demonstrated in their performance on formal admission tests.[9] Female students tend to score higher on the verbal and general information subtests of the Medical College Admission Test (MCAT). Male students tend to have slightly higher scores on the science and quantitative subtests. Most successful applicants to medical school demonstrate undergraduate training in the natural sciences. There is no evidence that female and minority candidates more often major in nonscience specialties at the undergraduate level. Men and women are comparable in the extent and nature of their formal education.[10]

What effects, if any, do differences in social class background and education achievements have on the attitudes and behavior of medical students? Do students from lower status background make better physicians than their higher status colleagues? Several studies of performance and achievement in medical school have compared blacks and other ethnic minorities to whites. In one study, researchers compared Anglo and Cuban students' performance in a surgical clinical clerkship. They found that Cuban females showed lower tolerance for ambiguity and felt less in control of their lives than did both Anglo and Cuban males. Cuban females also scored lower on written and verbal examinations. However, Cuban females received higher scores in faculty assessments of their behavior with patients than did male and female Anglos and Cuban males. The authors suggest that the overall poor performance of Cuban females is the result of their special role in the Cuban family, which prevents them from being assimilated into the mainstream U.S. culture.[11] The authors focus their attention on the overall poor academic performance of Cuban females, but appear less concerned with their observed abilities to relate and care for patients.

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[8] Dube, W.F. *Datagram: socioeconomic background of minority and other U.S. medical students, 1976-77*. JOURNAL OF MEDICAL EDUCATION, 53 (5), 443-445 (1978).

[9] Roessler, R., Lester, J.W., Butler, W. T., *et al*. *Cognitive and personality variables in the prediction of preclinical performance*. In PROCEEDINGS OF THE SEVENTEENTH ANNUAL CONFERENCE ON RESEARCH IN MEDICAL EDUCATION (Association of American Medical Colleges) (1978).

[10] Thomas-Forgues, M. and Erdmann, J.B. *MCAT scores and academic records of natural science and humanities majors applying to medical school, 1978-79*. JOURNAL OF MEDICAL EDUCATION, 55 (11), 971-972 (1980).

[11] Linn, B.S. and Zeppa, R. *Sex and ethnicity in surgical clerkship performance*. JOURNAL OF MEDICAL EDUCATION, 55 (6), 513-520 (1980).

Medical educators appear to have separate sets of concerns in evaluating the performance of female medical students and that of racial and ethnic minorities. The major focus in studies of female medical students is the type of practice they desire, their attitudes and behavior toward patients, and their commitment to the medical profession. Building on the cultural stereotype of women in the general society, researchers have attempted to demonstrate that women are, in fact, more nurturing, less achievement-oriented, and less aggressive in their practice of medicine than their male counterparts. In studying the performance of racial and ethnic minorities, researchers draw attention to the educational deficiencies of these students and the development of remedial programs designed to rectify these deficiencies. For women medical students, personality traits and career goals are viewed as potentially significant in determining the way the female physician will eventually behave in practice. For racial and ethnic minorities, concern over their relatively poorer academic performance has been the primary focus of study.

There have been several attempts to study the psychological characteristics of applicants and enrollees and to examine differences between men and women. In general, admission to medical school is seen as a highly competitive process, designed to select students who are academically gifted and strongly committed to a career in professional medicine. The science-oriented curricula in all medical schools encourage the view of medical practice as a field requiring "tough-minded" professionals, whose primary concerns are with the clinical skills and techniques of medical science. More "tender-minded" students, those with special concern for the human qualities of the patient and his or her family and with a more humanitarian view of medicine, do not readily fit into this image of professional medicine.

Examination of the psychological characteristics of medical students—both male and female—reveals a complex constellation of personal qualities among successful applicants. In one study, women showed higher capacity for status and greater tolerance, intellectual efficiency, and sociability than men. They also had greater vocational interests in social service and literary and artistic pursuits. Men showed greater propensity for salesmanship and mechanical interests.[12] In general, however, both men and women were quite similar in their psychological characteristics. Compared with a sample of college students, both male and female medical students were more empathic and able to give succor and nurturance. They are also less dominant than college students generally.[13,14]

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[12] Roessler, R., Lester, J.W., Butler, W.T., *et al. Cognitive and personality variables in the prediction of preclinical performance*. In PROCEEDINGS OF THE SEVENTEENTH ANNUAL CONFERENCE ON RESEARCH IN MEDICAL EDUCATION (Association of American Medical College) (1978).

Differences between men and women medical students do not themselves suggest clear recommendations for modifying medical school admission criteria. The differences are less than those between men and women in the general population and the similarities persist throughout their medical careers. In short, sex appears to be a poor criterion for evaluating the personal qualities of a physician.[15]

Commitment to a career is an important quality for students pursuing professional training. Success in medical school and a mature practice require arduous training and long hours. In the early 1960s, some educators were concerned that the work history of females in the general population, characterized by interruptions for family care and childbearing, would affect the quality of medicine practiced by female physicians. But the career patterns among female physicians indicate a shift away from part-time work and career interruptions for childbearing[16] that is consistent with trends for women professionals in the general population. These women demonstrate a strong commitment to the medical profession complemented by their responsibilities to home and family.[17]

The greater proportion of women enrolled in U.S. medical schools has produced a convergence in the career patterns of male and female students. Historically, women physicians selected specialties in pediatrics and psychiatry, and tended to avoid, or were encouraged to avoid, specialties such as surgery.[18] In a recent analysis of specialty choices from 1970 to 1973, Weisman and others found that the proportion of female medical students selecting pediatrics and psychiatry actually

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[13] *Ibid.*

[14] Fruen, M.A., Rothman, A.I., and Steiner, J.W. *Comparison of characteristics of male and female medical school applicants.* JOURNAL OF MEDICAL EDUCATION, *49* (3), 137-141 (1974).

[15] Eisenberg, C. *Similarities and differences between men and women as students.* JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, *36* (2), 45-50 (1981).

[16] Weisman, C.S., Levine, D.M., Steinwachs, D.M., and Chase, G.A. *Male and female career patterns: Specialty choices and graduate training.* JOURNAL OF MEDICAL EDUCATION, 55 (October), 813-825 (1980).

[17] Nadelson, C.C., Notman, M.R., and Lowenstein, P. *The practice patterns, life styles, and stresses of women and men entering medicine: A follow-up study of Harvard Medical School graduates from 1967 to 1977.* JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, *34* (11), 400-406 (1979).

[18] Renshaw, J.E. and Pennell, M.Y. *Distribution of women physicians, 1969.* WOMAN PHYSICIAN, *26*, 187-195 (1971).

decreased. Furthermore, there was a noticeable trend toward a convergence among men and women students in both their preferences for a specialty and their tendency to change specialty preferences in the course of their medical education. The study also indicated that men were showing an increasing preference for primary care specialties such as family practice and internal medicine.[19] It would appear that the increasing proportion of women enrolled in medical school has resulted in a change in career orientations and specialty preferences for both men and women.

Generally, it appears that the behavior of men and women medical students is becoming more similar. In one recent study, Beil and her colleagues[20] classified male and female students as "strongly feminine," "strongly masculine," and "androgenous," based on responses to the Bem Sex-Role Inventory.[21] They found that the sex-role concept was a poor prediction of specialty choice. In addition, they found considerable similarity between men and women students in several key respects. Both men and women planned to work shorter hours in practice and showed some tendency to select a practice setting that would allow time for a personal life apart from their medical career. There was a general sentiment favoring a group practice that would relieve them of administrative tasks. This finding has been confirmed in studies by Rosen and others[22] and by Kutner and Brogan,[23] who found that students in general preferred a style that would decrase the stress involved in working long hours with a single-minded commitment to medicine as the sole focus of the physician's life.

The convergence between men and women medical students in terms of their attitudes and orientations to their profession encourages one to look for a similar convergence in their attitudes and behavior toward patients. A number of studies have indicated that women are more responsive to patients. They appear better able to express tension, grief, and emotional reactions in medical practice.[24] They appear to be slightly more verbal with patients and less aggressive, distant, and impersonal.[25] These findings are consistent with results demonstrating that women physicians tend to be more liberal and egalitarian in their attitudes than male physicians.[26] However, men and women in the same medical specialty demonstrate remarkably similar attitudes. Heins and others also report that older women physicians are slightly more receptive to innovative medical and educational policies.[27]

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[19] See note 16, at 817.

[20] Beil, C. *A comparison of specialty choices among senior medical students using Bem Sex-Role Inventory scale.* Journal of the American Medical Women's Association, 35 (7), 178-181 (1980).

[21] Bem, S.L. *The measurement of psychological androgeny.* Journal of Consultation in Clinical Psychology, 42, 155-161 (1974).

[22] Rosen, R.H., *et al. Practice plans of today's medical students.* Journal of Medical Education, 56 (1), 57-59 (1981).

[23] Kutner, N.G. and Brogan, D.R. *A comparison of the practice orientation of women and men students at two medical schools.* Journal of the American Medical Women's Association, 35 (3), 80-86 (1980).

[24] Dickinson, G.E. and Pearson, A.A. *Sex differences of physicians in relating to dying patients.* Journal of the American Medical Women's Association, 34 (1), 45-47 (1979).

In conclusion, it appears that significant change in the attitudes and behaviors of practicing physicians cannot be effected simply by increasing the number of females who practice medicine. In fact, as their proportion in medical school increases, women tend to develop attitudes and interests similar to men. Their unique contribution to changing the values of the medical profession is felt in terms of legitimizing interests in aspects of life outside of professional practice and allowing both men and women to realize a greater diversity in their personal and professional lives.

In 1970, the Association of American Medical Colleges (AAMC) recommended that U.S. medical schools increase the proportional enrollment of underrepresented minorities (blacks, Hispanics, native Americans) from its level then of 2.8% to 12% by 1975-76.[28] The rationale for this recommendation was based on the lack of adequately trained physicians serving racial and ethnic minorities as well as the need to reform medical school admission procedures regarded as discriminatory. Since publication of the task force report, proportional enrollments of blacks and other minorities has increased slightly over this ten-year period. Racial and ethnic minority students constituted 9.1% of the total first-year enrollment and 8% of the total enrollment in 1979-80.[29] While this represents a noticeable improvement since 1970, it is considerably short of the AAMC stated objectives. In fact, recent evidence suggests that minority-student applications to U.S. medical schools is declining slightly.[30]

Several recent studies have suggested that black and other minority physicians form a unique subgroup within the medical profession. Are these physicians more open, responsive, and humane to their patients than their white colleagues are? Few, if any, studies have addressed this question directly. The primary focus of research on black and minority physicians has been on their educational and intellectual deficiencies, and on methods for alleviating the high attrition rate among black medical students.[31,32] Several studies have documented higher levels of psychological stress among black students, as well as a perceived lack of social supports available to offset the strains derived from their minority status.[33] Higher levels of stress among black medical students may have an impact on their attitudes and behavior toward patients. However, little documentation of either a direct or indirect effect is available in the literature.

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[25] Cartwright, L.K. *Personality differences in male and female medical students.* Psychiatry in Medicine, 3, 213 (1972).

[26] Heins, M. Hendricks, J., Martindale, L., and Smock, S. *Attitudes of women and men physicians.* American Journal of Public Health, 69 (11), 1132-1139 (1979).

[27] *Ibid.*, at 1135.

[28] Nelson, B.W., Bird, R.A., and Rodgers, G.M. *Expanding educational opportunities in medicine for blacks and other minority students.* Journal of Medical Education, 45, 731-736 (1970).

[29] See note 6, *supra.*

[30] Gordon, T.F. and Johnson, D.G. *Applicants for 1978-79 first-year medical school class.* Journal of Medical Education, 55 (1), 74-76 (1980).

One purpose of increasing the representation of blacks in the medical profession is to make the medical community more responsive to the values and needs expressed by the black community. Black medical students may be encouraged to develop a strong commitment to community involvement and a political ideology that favors liberalism and social change. In an empirical test of this contention, Dorsey-Young compared first- and fourth-year medical students at Howard University for their development of a communal value orientation in the course of their medical education.[34] In her study, 94% of the first-year students stated that their reasons for choosing medicine as a career derived from a desire to make sick people well. That figure dropped to 89% among fourth-year students. Of both first- and fourth-year students, 75% stated that their reasons for choosing a medical career derived from a desire to become involved with people on a community level; 71% of first-year students compared to 73% of fourth-year students expressed the desire to change society as a fundamental reason for their choice of a career in medicine. A majority of the medical students interviewed felt that their interest in community involvement grew stronger after entering medical school.

Clearly, the task of educating black physicians to see their roles as community leaders and to function as agents of social

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[31] Johnson, D.G., Smith, V.C., and Tarnoff, S.L. *Recruitment and progress of minority medical school entrants, 1970-72*. JOURNAL OF MEDICAL EDUCATION, *50*, 731-755 (1975).

[32] Johnson, D.G. and Hutchins, E.B. *Doctor or dropout? A study of medical student attrition*. JOURNAL OF MEDICAL EDUCATION, *41*, 1097-1269 (1966).

[33] Strayhorn, G. *Social supports, perceived stress, and health: The black experience in medical school—a preliminary study*. JOURNAL OF THE NATIONAL MEDICAL ASSOCIATION, *72* (9), 869-881 (1980).

[34] Dorsey-Young, F. *Value socialization of black medical students at the Howard University College of Medicine: A case report*. JOURNAL OF THE NATIONAL MEDICAL ASSOCIATION, *72* (3), 247-258 (1980).

change has profound implications for changing the value orientations within the medical profession. Whether black students can be educated to take on this new role in the course of their medical education depends upon the commitment of medical educators to developing a communal value system among student physicians. The experience of black medical students in an all-black college of medicine, such as Howard University, is undoubtedly unique. These students are relieved from the pressure of being tokens and encouraged to develop a set of attitudes currently underrepresented within the medical profession. For black students in traditional, white-dominated medical schools, the opportunity to develop their special interests may be mitigated by the need to take on the values and ideology of the dominant group. In such situations, the black student may be pressured to conform to the ideological preferences of the majority.

A commitment to communal values and an orientation to helping to make sick people well are both central to the professional ideals of medicine. If black medical students are uniquely receptive to developing such an orientation in their professional careers, then increasing the representation of blacks in the profession will have profound effects on the practice of medicine. One may anticipate that increasing the proportion of blacks in medicine will allow such ideals to flourish. In this respect, policies that promote black enrollment in medical schools may foster a renewed commitment within the medical community to the ideals of service and humanitarianism.

Policies directed toward changing the racial, ethnic, and gender-related characteristics of enrollees in U.S. medical schools may have some short-term effects in changing the practice styles of members of the medical profession. However, policies based on assumptions about the attitudinal differences of women and minorities have built-in limitations. The majority of medical students and practicing physicians continue to be white males. Policies based on the discernible characteristics leave untouched within the selection process the structural biases that may encourage applicants who possess values consistent with the majority. They also assume that the educational process itself takes on a secondary importance in socializing students into the ideology of the profession. In drafting recommendations directed toward changing the attitudes and behavior of physicians, careful attention must be paid to the majority, whose influence on learning and maintaining professional values is most salient. If medical school admission procedures encourage applicants who have developed a commitment to the scientific aspects of medicine to the exclusion of its more humane orientations, then those admissions procedures themselves require careful and critical scrutiny.

The educational experiences of future physicians begin early in a student's life. As Pelligrino points out, the decision to pursue a medical career requires the student to make an early commitment to a career and target his or her academic efforts toward winning a place in medical school. Prospective medical students are all highly motivated individuals. They are consummate "hurdle jumpers" and are well equipped to meet the challenges they perceive as central to winning a place in medical school.[35] The majority of medical students currently enrolled were undergraduate majors in the natural sciences. Many prospective medical students see undergraduate natural sciences training as essential to their success in gaining admission.[36] Clearly, medical school admission committees encourage applicants with undergraduate majors in the "pre-medical sciences of biology, chemistry, or zoology."[37] The undergraduate educational experiences of most successful applicants is noticeable for the absence of exposure to the concepts and skills included in the social sciences and humanities. This body of knowledge is essential to the development of a humanitarian orientation among prospective students and the fostering of skills in communication and counselling in medical treatment.

Undergraduate training in the humanities and social sciences appears to influence the development of the clinical skills of student physicians. In one recent study, Dickman and others have demonstrated that students with nonscience undergraduate majors actually scored higher in 8 of the 15 basic science courses compared to medical students with science undergraduate majors. In addition, students with nonscience undergraduate majors scored significantly higher on the Behavioral Science subtest of the National Board Medical Examination. However, there was no significant differnce in distribution of grades in clinical clerkships between science and nonscience undergraduate majors.[38] The authors recommend that admissions committees, academic advisors, and prospective students reevaluate the need for students to concentrate in the natural sciences as a prerequisite for admission to medical school.

Exposure to the social sciences and humanities at the undergraduate level may sensitize prospective medical students to the concepts and skills essential to becoming effective and responsive communicators. While some medical educators

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[35] Pellegrino, E.D. *Pruning an old root: Premedical science and medical school.* Journal of the American Medical Association, *243* (24), 2518-2519 (1980).

[36] Gordon, T.L. and Johnson, D.G. *Study of U.S. medical school applicants, 1977-78.* Journal of Medical Education, 54 (9), 677-702 (1979).

[37] Gough, G.H. *The recruitment and selection of medical students.* In Psychosocial Aspects of Medical Training (R.H. Combs and C.H. Vincent, eds.), Springfield, Ill.: Charles C. Thomas, 1971.

[38] Dickman, R.L., Sarnacki, R.E., Schimpfhauser, F.T., and Katz, L.A. *Medical students from natural science and nonscience undergraduate backgrounds.* Journal of the American Medical Association, *243* (24), 2506-2509 (1980).

Kepler and others have presented findings from an evaluation of a course in Human Values in Medicine offered to first-year students at the Baylor College of Medicine in Houston.[45] The 12-week course is designed to introduce students through discussion sessions to the basic tenets of the Jewish, Roman Catholic, and Protestant faiths that may be important to the outcome of medical treatment. A semantic differential test was administered to students before and after the course, and their responses were compared to a control group. Results showed that the enrolled students demonstrated increased receptivity to the concept of chronic disease and interest in disease prevention as well as greater awareness of patients. The authors concluded that the course had been effective in directing students' attention toward the humanistic aspects of medical practice.

Many major medical schools in the United States and abroad offer comprehensive courses in social science and medicine for first- and second-year students.[46,47,48] The thrust of these basic courses is to provide students with a fundamental understanding of the social psychology dimensions of medical treatment and encourage them to develop communicative and supportive relationships with their patients. However, the transition from preclinical to clinical education in medical school is fraught with difficulties for many students. Much of the criticism of formal course work in preclinical education is directed to the problems students face in their efforts to apply knowledge gained in formal course work in their interactions with real patients. Many of the more innovative approaches to instructing students in the art of communicating with patients consciously employ techniques designed to enhance the practical relevance of the course content to actual situations students may encounter in their clinical experience. One such technique uses videotaped interviews between physicians and patients to demonstrate effective interviewing styles.

In one such experiment, Ber and Alroy presented students with a videotaped history-taking interview.[49] Students viewed the tape in small groups of ten to twelve. Discussion sessions following their observations were designed to develop their skills in evaluating information obtained in the interview concerning the patient's illness and possible treatment. Jones, Hornblow, and Tiller employed a similar technique in a course designed to instruct second-year students in interpersonal skills in the care of old-age pensioners.[50]

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[45] Kepler, M.O. and Saslow, H. *Attitudinal changes in medical students taking a course in human values.* SOUTHERN MEDICAL JOURNAL, 69 (1), 21-23 (1976).

[46] Torregrosa, H.R. *Man and his environment: a comprehensive course for medical students.* JOURNAL OF MEDICAL EDUCATION, 55 (May), 459-461 (1980).

[47] Hayes, S.C., Walker, W.L. and Channon, L.D. *Ongoing evaluation of a behavioral sciences course for medical students: uses, methods, limitations.* MEDICAL EDUCATION, 13, 194-198 (1979).

[48] Jones, K.V., Hornblow, A.R., and Tiller, J.W.G. *Evaluation of teaching on interpersonal interactions.* MEDICAL EDUCATION, 15 (1), 43-45 (1981).

[49] Ber, R. and Alroy G. *The teaching of history-taking and diagnostic thinking.* MEDICAL EDUCATION, 15, 97-99 (1981).

The use of videotaped interviews in courses at the preclinical level provide an opportunity to present students with a model for physician-patient interaction. Discussion sessions appear to be an effective method in enhancing students' awareness of the communication process. This technique serves to introduce students to the complexities they will unavoidably encounter in their clinical training. It may be especially useful in easing the students' transition from the preclinical to the clinical phase of their education.

The structure of medical education, with its traditional separation between formal course work in the first and second years and clinical clerkships in the third and fourth years, creates the problem of transition and carry-over from preclinical to clinical training. One strategy for mitigating the effects of this has been developed at the State University of New York at Buffalo School of Medicine.[51] During a three-day orientation program, entering first-year students are introduced to their first patient prior to the beginning of classes. One patient is selected for presentation to each entering class. The program begins with a written case history distributed one day prior to the presentation. The patient's physician introduces the patient to the class, reviews the history, and moderates questions from the students. Presentations by senior physicians from medical specialties relevant to the patient's problem are given throughout the program. The students are given immediate exposure to basic and clinical sciences as well as to the human dimensions of the patient and his or her problem. Under this program, "the student . . . abruptly confronts reality in medicine and hopefully recognizes the essential role of basic information and decision-making in complex clinical problems."[52]

Training in interviewing techniques at the clinical level of medical education combines formal course work with practical experience in dealing with patients. Formal seminars and informal discussions with clinical supervisors provide students with basic information useful in their clinical clerkships, while the opportunity to interact with actual patients allows them to apply their newly gained information and understanding. Sevhave challenged the contention that medical students are deficient in their undergraduate training in the humanities and social sciences,[39] few have questioned the value of nonscience course work in the undergraduate curriculum in providing a broadly based education for prospective physicians.[40]

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[50] See note 48, *supra*.

[51] Schimpfhauser, F., Katz, L.A., and Carr, E.A. *The doctor's first patient: medical student orientation through case presentation*. JOURNAL OF MEDICAL EDUCATION, 55 (July), 622-624 (1980).

[52] *Ibid*. at 622.

In educating physicians for better communication with patients, there is a need to reexamine the criteria for admitting students to medical school, not only to allow more women and minorities to enter the profession, but to encourage all prospective students, regardless of their race, ethnicity, or gender, to develop the skills and sensibilities which they will need in order to practice as humane and caring physicians.

Teaching Student Physicians to Communicate with Patients—"Experiments" in Medical Education

The need to train students to communicate with patients has spawned a large and ever-growing number of innovations in the medical school curricula. At the preclinical level, innovative courses in diagnostic interviewing, physician-patient communication, patient counselling, and behavioral medicine are offered to students. The major thrust of these courses is to introduce medical students to the basic concepts and skills in the art of effective communication.

The plethora of recent studies on the design and evaluation of these courses reveal two general approaches. The first incorporates basic social science concepts and training in physician-patient communication into standard first- and second-year course work. An alternative approach provides individual courses in interviewing and counselling which are distinct from basic science courses offered during the preclinical phase.

In their survey of 107 medical schools, Veatch and Sollitto[41] reported that 69 schools incorporate instruction in medical ethics and the social aspects of medicine into traditional course work, while 53 offer distinct courses in medical ethics and other related topics. Veatch and Sollitto found that a significant number of schools were committed to teaching medical ethics and physician-patient communication in the form of an informal transmission of values imparted to students throughout their educational careers. At the time of this report, there remains no clear empirical evidence concerning the effectiveness or lack of effectiveness of this approach in promoting more open communication between physicians and patients in clinical practice. The incorporated approach to education in the social sciences derives from the traditional apprenticeship model in medical education and has led to some resistance to the introduction of more systematic and structured course work in physician-patient communication.

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[39] Niemi, R.G. and Phillips, J.E. *On nonscience premedical education: surprising evidence and a call for clarification.* Journal of Medical Education, 55 (3), 194-200 (1980).

[40] Prioreschi, P. *Medical education, irrelevancy and the humanities.* Medical Hypothesis, 6 (5), 509-515 (1980).

[41] Veatch R.M. and Sollitto, S. *Medical ethics teaching. Report of a national medical school survey.* Journal of the American Medical Association, 235 (10), 1030-1033 (1976).

Despite some resistance to special course work in interviewing and communication at the preclinical level, such courses are becoming increasingly frequent in the standard curricula of most medical schools. Evaluation of such courses has produced ambiguous findings concerning their overall effectiveness. For example, Smith and others[42] measured change in interviewing behavior and attitudes among students enrolled in a course in interviewing techniques at the University of Washington School of Medicine. A comparison of precourse and postcourse scores showed the greatest change was in students' preferences for responses aimed at understanding the patient, with a decreased preference for evaluative, interpretive, and supportive responses. Students continued to prefer "probing"-type responses both before and after taking the course.

A similar study conducted at the University of Hawaii School of Medicine measured changes in students' attitudes toward patients following completion of a course in Basic Interviewing Techniques. A certain number of first-year students were subjected to an eight-week short course that included traditional lectures in the techniques of communication and student participation in two kinds of role-playing.[43] In the first type, the course instructor played the part of the patient with students rotating in the role of physician. The instructor provided feedback to each student in an attempt to enhance empathy, immediacy, and personal meaning. In the second type of role-playing, students took turns in the roles of patient, physician, and evaluator, and were encouraged to practice their newly learned behaviors with real patients, family, and friends. Results showed significantly higher empathy levels (measured on the Truax Accurate Empathy Scale[44]) among students who received the training. The authors concluded that skills in empathy can be successfully taught and that such training programs are effective in preparing students to relate to patients.

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[42] Smith, C. K., Hadac, R.R., and Leversee, J.H. *Evaluating the effects of a medical interviewing course taught at multiple locations.* JOURNAL OF MEDICAL EDUCATION, 55 (9), 792-794 (1980).

[43] Fine, V.K. and Therrier, M.E. *Empathy in the doctor-patient relationship: skill training for medical students.* JOURNAL OF MEDICAL EDUCATION, 52 (9), 752-759 (1977).

[44] Truax, C.B. *A scale for the measurement of accurate empathy.* PSYCHIATRIC INSTITUTE BULLETIN, 1 12 (1961).

eral studies have evaluated the effects of clinical experiences on students' attitudes and behavior toward patients. One broad set of innovations involves the introduction of interpersonal skills (IPS) training programs into the medical school curricula.[53] Although most IPS programs are designed for first- and second-year students, a number of schools provide IPS training for upper-level students. IPS training combines lectures and discussions in physician-patient communication with live demonstrations to illustrate proper interviewing techniques. Students are given the opportunity to practice their skills both through role-playing and through direct interaction with patients. Feedback is usually provided through videotaped replays of the student-patient interview with critical reviews by faculty and students.

Evaluations of the short-term effectiveness of IPS training indicate it is reasonably effective in producing a change in students' attitudes and behavior in favor of more open and nondirective interviewing styles.[54] The multifaceted approach to medical interviewing embodied in IPS programs and the diversity of content and organization among such programs produce variations in results. In addition, several studies suggest that the programs result in only short-term behavioral changes.[55] In a more recent study of the long-term effectiveness of interpersonal skills training, Kauss and others found no difference in interview behaviors between house officers who had such training in medical school and those who did not.[56] However, after controlling for the comprehensiveness of the training, the researchers found that house staff who received more comprehensive training demonstrated long-term maintenance of interviewing techniques learned through their IPS training. The authors concluded that training in interpersonal skills can have moderate long-term effects if the training is comprehensive and if several methods of training (videotape feedback, role play, and formal instruction) are employed.

While formal instruction in physician-patient communication, role-playing, and videotape feedback are useful in fostering student's awareness of the patient in the treatment process, all these approaches exclude the patient from the process of evaluating student performance in the interview and examination. These methods may tend to perpetuate the impression that the interview and examination are primarily in the control of the physician. Including the patient's experience of the encounter encourages a view of the interaction as a two-way process in which both physician and patient make unique and reciprocal contributions to the communication process.[57]

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[53] Kahn, G., Cohen, B., and Jason, H. *The teaching of interpersonal skills in U.S. medical schools.* Journal of Medical Education, 54 (1), 29-35 (1979).

[54] Carroll, J.G. and Monroe, J. *Teaching medical interviewing: a critique of educational research and practice.* Journal of Medical Education, 54, 498-500 (1979).

[55] Barbee, R.A. and Feldman, S.E. *A three-year longitudinal study of the medical interview and its relationship to student performance in clinical medicine.* Journal of Medical Education, 45, 770-776 (1970).

[56] Kauss, D.R., Robbins, A.S., Abrass, I., *et al. The long-term effectiveness of interpersonal skills training in medical schools.* Journal of Medical Education, 55 (7), 595-601 (1980).

In an effort to increase the student's sensitivity to patients during clinical training a number of programs have been developed that use patients as teachers and evaluators. This innovative approach has been used in clinical training programs in obstetrics and gynecology,[58] urology,[59] and family practice.[60] The intent of these programs is to encourage a patient-centered approach in diagnostic interviewing and physical examination.

One such program, developed at the University of Sheffield, uses volunteer patients. Students in their first year of clinical training are asked to interview the patient and discuss the interview with him. The students are instructed to conduct the interview as if it were the initial meeting of what would develop into a long-term treatment relationship. The patient is asked to act as though the interview were the first meeting with a new physician. In general, the researchers found that some students were reluctant to explore highly personal issues with the patients, such as financial problems or sexual relationships. Feedback from the patients provided students with an opportunity to examine the assumptions they had made about the patient and become more aware of their own resistance to discussing sensitive topics.[61]

The effectiveness of this technique depends upon the patient-instructors' understanding of their own role in the interview. This requires careful selection and training of patient volunteers. Several studies have reported elaborate methods for recruiting and training patient volunteers to serve as instructors for medical students in clinical training. In one study, Barnes and others[62] developed a patient-advocate-interviewer (PAI) model in an attempt to both assure informed consent from volunteer patients and instruct them in the teaching-patient role. The authors then compared patients who had undergone the training to a group of control patients who had not received the instruction. Comparisons of responses obtained from a patient evaluation questionnaire showed that patients receiving the instruction were better informed about their role and the status of the students and more comfortable about being interviewed by a student physician.

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[57] Kent, G.G., Clarke, P., and Dalrymple-Smith, D. *The patient is the expert: a technique for teaching interviewing skills.* MEDICAL EDUCATION, 15 (1), 38-42 (1981).

[58] Kretzschmar, R.M. *Evolution of the gynecology teaching associate or education specialist.* AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY, 131, 367-373 (1978).

[59] Behrens, A., Barnes, H.V., Gerber, W.L., *et al. A model program for teaching sophomore medical students the essentials of the male genital-rectal examination.* JOURNAL OF MEDICAL EDUCATION, 54, 585 (1979).

[60] Anderson, K.K. and Meyer, T.C. *Using instructor-patients to teach physical examination skills.* MEDICAL TEACHER, 1, 244 (1979).

[61] See note 57, *supra*, at 41.

[62] Barnes, H.V., Albanese, M., and Schroeder, J. *Informed consent: the use of inpatients as teaching patients for sophomore medical students.* JOURNAL OF MEDICAL EDUCATION, 55 (August), 698-703 (1980).

In an effort to increase the relevance and immediacy of the student's experience in clinical interviewing, a few studies have employed novel techniques for providing students with feedback during patient interviews. Pilowsky[63] describes a method for developing clinical observational skills among clinical students. Videotapes of students' interviews with patients are studied and reviewed in order to discuss the verbal and nonverbal behavior of both participants. The taped interview is interrupted at key points and the substance of the interaction is reviewed and discussed. Both students and instructors participate in the discussion to provide evaluative comments. However, patients are not given the opportunity to view the tape or participate in the discussion.

More explicit methods for providing feedback during the course of the medical interview have used electronic remote broadcasting equipment. The equipment allows for two-way communication between the student and the instructor during the course of the interview. In one such experiment, Hunt[64] used a combination of one-way mirror observation and an electronic "bug-in-the-ear." The student interviewed the patient in an observation room equipped with a one-way mirror. The student wore a remote earphone with audio pick-up from the instructor who observed the interivew from behind the mirror. While the audio equipment was somewhat awkward for the students, it allowed the instructor to provide immediate feedback to the students.

Clinical experience in interviewing patients is essential to the development of communication skills among student physicians. The major approach taken in the clinical phase of education involves providing students with practical experience in relating to patients. However, the quality of these initial experiences may have a negative effect on students' attitudes toward patients. In his discussion of student attitudes toward alcoholism, Nocks[65] observed that many students undergo a great deal of negative learning in their clinical experience with alcoholic patients that strongly influences their behavior toward these patients. Students encounter alcoholic patients in the emergency room or acute care center where the patient typically rejects the student's counsel and offers of help.

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[63] Pilowsky, I. *The interrupted interview: a method for facilitating the development of clinical observational skills.* MEDICAL EDUCATION 12, 357 (1978).

[64] Hunt, D.D. *'Bug-in-the-ear' technique for teaching interview skills.* JOURNAL OF MEDICAL EDUCATION, 55 (August), 964-966 (1980).

In an attempt to offset the student's negative experience in treating alcoholic patients, Nocks designed a six-week short course on alcoholism offered at the West Haven VA Medical Center for students at Yale University. The course was a required part of the students' clinical clerkship in psychiatry. It focused on changing students' negative attitudes toward alcoholics and included course discussions on the nature of alcoholism as well as dynamic explorations of the students' own feelings about its use. The course has been effective in stimulating student interest in alcoholism and promoting a more positive attitude toward the alcoholic patient.

In their clinical experience, students encounter patients with many forms of chronic or incurable disease that they may feel ill-equipped to face. This is especially evident in the care and treatment of geriatric patients. One program developed at the University of Oregon School of Medicine is designed to introduce students to humanistic geriatric health care.[66] The program employs junior and senior medical students as live-in facilitators at a publicly subsidized housing project for the elderly. Students participate in weekly seminars, rotate for emergency and weekend calls, and also hold weekly health clinics at the housing center. The program provides students with experiential learning in humanistic health care as well as exposure to ambulatory care for elderly patients. The project has benefited students by educating them to accept responsibility for clinical assessment and case management.

Care of terminally ill patients represents a unique dilemma for students in their initial clinical experiences. Courses on death and dying currently offered in U.S. medical schools generally employ case presentations, lectures, and discussions by interdisciplinary teams to acquaint students with the psychosocial issues involved in caring for the dying patient.[67] One program instituted at the Dartmouth Medical School also includes instruction in supportive skills in caring for chronically ill patients.[68] Clinical experience in treating the dying patient is provided during a seven-week clerkship in clinical psychiatry. Students first observe how patients respond to life-threatening conditions and later provide individual counselling and support under the supervision of a staff professional. Developing the interpersonal skill to relate intimately and honestly to the dying patient appears to be particularly difficult for the medical students. Informal evaluations of the program suggest that students develop a feeling that they are more capable of responding to the emotional and medical needs of dying patients. Despite the difficulties in teaching medical students to communicate with dying patients, efforts to improve communication skills have met with some success.[69]

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[65] Nocks, J.J. *Instructing medical students on alcoholism: what to teach with limited time.* Journal of Medical Education, 55 (10), 858-864 (1980).

[66] Rose, B.K. and Osterud, H.T. *Humanistic geriatric health care: an innovation in medical education.* Journal of Medical Education, 55 (11), 928-932 (1980).

[67] Smith, M.D., McSweeney, M., and Katz, B.M. *Characteristics of death education curricula in American medical schools.* Journal of Medical Education, 55 (10), 844-850 (1980).

Educational innovations for medical students in the art of communicating with patients have been designed and implemented in both preclinical and clinical phases of training. The study by Kauss and others[70] reviewed above suggests that the long-term efficacy of such training is influenced by the comprehensiveness of the initial educational programs. Students who receive more complete instruction that includes both formal course work and supervised practical experience are more likely to maintain their newly developed skills when they enter into mature practice.

However, the question remains as to whether educating students in the art of physician-patient communication should be incorporated into undergraduate course work, preclinical freshman and sophomore courses in medical school, or clinical clerkships. One study conducted at the UCLA School of Medicine indicated significantly better communication skills among house staff who had received some interpersonal skills training in medical school.[71] In addition, there is some evidence to suggest that such training may be more effective in producing long-term behavioral and attitudinal changes when it is provided at the graduate level. For example, several studies have documented that effective communication skills can be developed among physicians in internship and residency programs.

Residents who were judged by the faculty to have better clinical skills and who expressed a desire to enter private practice all demonstrated good communication skills with patients. In addition, house staff physicians with better communication skills were less likely to have patients who failed to keep their clinic appointments. The authors suggest that physicians who value an "exploratory, nondirective style of interaction with patients are more likely to be evaluated by their attending physicians as being first-class clinicians, despite the fact that critics of the nondirective approach have often suggested that it is an inefficient and nonproductive way to interview."[72] Furthermore, the findings suggest that early and intensive training in interpersonal communication appears to have long-term effects on the communication styles of residents.

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[68] Nelson, W.A. *Clinical teaching of care for terminally ill in a psychiatric clerkship.* JOURNAL OF MEDICAL EDUCATION, 55 (July), 610-615 (1980).

[69] Anderson, J.L. *A practical approach to teaching about communication with terminal cancer patients.* JOURNAL OF MEDICAL EDUCATION, 54 (10), 823-824 (1979).

[70] See note 56, *supra.*

[71] Linn, L.S. and Wilson, R.M. *Factors related to a communication style among medical house staff.* MEDICAL CARE, 18 (10), 1013-1019 (1980).

Objective assessments of the communnication skills of physicians all suggest that intensive training in physician-patient communication results in behavioral change among physicians.[73] Skills in nondirective interviewing, once established, require continuing and intermittent reinforcement. However, those few studies that have attempted to document the long-term effects of such training all suggest a persistent pattern of behavior among physicians and students who acquire such skills.

The studies reviewed above all suggest that communication skills can be taught to students in medical school as well as to interns and residents. In their recent review of the literature on training in communication skills, Sanson-Fisher and Maguire[74] conclude that effective communication can be taught to medical students. However, they also suggest that the development of effective training programs and the evaluation of those programs suffers from "too much enthusiasm and too little science."[75]

Students who are exposed to the concepts and skills of nondirective interviewing and open communication appear well able to acquire appropriate interviewing behavior and maintain that behavior in their interactions with patients. The efficacy of training depends on the adequacy of the initial instruction and the availability of opportunities to practice those skills in the clinical care of patients. Sanson-Fisher and Maguire conclude that although training students in physician-patient communication is becoming increasingly more noticeable in medical education, current training does not ensure that students will acquire the desired skills. Once acquired, these skills must be reinforced by clinical faculty so that students maintain the ability to interact with patients, understand what patients are saying, and empathize with the patient.

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[72] *Ibid.* at 1018.

[73] Stillman, P.L. and Sabers, D.L. *Using a competency-based program to assess interviewing skills of pediatric house staff.* JOURNAL OF MEDICAL EDUCATION, 53 (June), 493-496 (1978).

[74] Sanson-Fisher, R.W. and Maguire, P. *Should skills in communicating with patients be taught in medical school?* LANCET, 2 (8193), 523-526 (1980).

[75] Sanson-Fisher, R.W., Fainbaim, S., and Maguire, P. *Teaching skills in communication to medical students: a critical review of methodology.* MEDICAL EDUCATION, 15 (1), 33-37 (1980).

In their review of instructional programs in medical interviewing, Tanner and Silverman[76] note that the lack of skilled teachers imposes a practical limitation on the quality of interpersonal skills training in U.S. medical schools. These authors have designed a teaching manual in interpersonal communication and have implemented a comprehensive training program in interpersonal skills at the University of Miami School of Medicine. The authors find that initial resistance to the program stems from a lack of skilled physicians and behavioral scientists able to conduct the training, inadequate motivation of faculty to teach such courses, variability in teaching styles and course content, and a lack of appropriate structure in teaching interpersonal skills. Use of the teaching manual appears to overcome most of these problems. Results from informal evaluations of the program suggest that students receiving the instruction all show attitude change in the direction of increased empathy and open communication with patients. In addition, use of the teaching manual appears to result in higher satisfaction among faculty instructors. They conclude that trained teachers as role models and a structured format are essential to an effective program.[77]

In the clinical phases of a student's education, physicians and residents take primary responsibility for instructing students in the art of talking with patients. Although an ideal vision of the clinical experience is based on a close, working apprentice-master relationship between a student and a senior faculty member, in fact a great deal of practical instruction and supervision is provided by house staff, who are themselves mere journeymen in the professional guild. As a result, students receive instruction from residents and junior faculty who themselves may be struggling to obtain mastery in the science and art of clinical practice. The level of training and the expertise among house staff and clinical instructors have important ramifications for the quality of instruction at the clinical level of training.

Educating student physicians in physician-patient communication is one aspect of the ethical education of physicians. As Siegler has noted, clinical teaching in medicine follows the apprenticeship model specified by Osler.[78] Following the Oslerian tradition, medical students are, or should be, encouraged to develop an understanding of the ethics of medical practice as they also develop their technical competence in the clinical aspects of patient care.

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[76] Tanner, L.A. and Silverman, G. *A teachers' guide to teaching medical interviewing.* MEDICAL EDUCATION, 15 (2), 100-105 (1981).

[77] *Ibid.* at 105.

[78] Siegler, M. *A legacy of Osler. Teaching clinical ethics at the bedside.*

Siegler notes a decreasing professional resistance to the notion of teaching medical ethics. However, questions recur in the literature about the timing of this training. When should communication skills be taught? What information should be given, and how should that information be presented to students through their educational experiences? The preclinical years provide an opportunity to expose students to the knowledge and experiences of specialists in interpersonal communication and the social psychology of health. The clinical years afford the student the opportunity to practice textbook knowledge in supervised interactions with real patients.

Many educational experiences in the clinical phase of training derive from the ongoing interaction among students and faculty. Carson and Curry[79] describe one successful program instituted at the University of Florida School of Medicine. In this program, specialty faculty in the behavioral sciences actively participate in clinical ward rounds, interacting with students and faculty in discussions of the ethical ramifications of patient care. Similar programs have been developed elsewhere and their advantages are many. First, the discussion of the ethical and communicative aspects of patient care are discussed in conjunction with the issues of clinical management of the patient. The relevance of specialized training in the behavioral science of medicine is enhanced through an integrated approach to patient care. The psychosocial and ethical dimensions of patient care are discussed in the context in which they actually occur. The need for effective communication with patients is demonstrated in the immediacy of the clinical environment and, finally, students are exposed to the practical consequences of ethical decisionmaking.

Resistance to Change in Physician-Patient Communication

The studies reviewed in this report underscore the commitment among medical educators to developing effective communication skills among medical students. The number of programs currently in place reflect a conscious effort to improve physician-patient communication in medical practice. Nevertheless, efforts to encourage open communication with

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Journal of the American Medical Association, *239* (10), 951-956 (1978).

[79] Carson, R.A. and Curry, R.W. *Ethics teaching on ward rounds.* Journal of Family Practice, *11* (1), 59-63 (1980).

patients continue to meet with resistance from some practitioners. Resistance to open communication with patients is deeply rooted in the values and attitudes of many physicians. There are several reasons why minimal communication with patients persists as an informal norm of professional practice.

First among these is the notion of clinical responsibility in treatment. The physician is trained to assume authority and responsibility for the medical care of the patient. The concept of clinical responsibility is deeply engrained in students through their clinical experiences. The student is trained to review information pertinent to the patient's care, make a diagnosis based on that information, and assume responsibility for the consequences of his or her clinical decisions. The process of becoming a physician requires that students learn to accept responsibility for the patient's physical well-being, especially when clinical decisions have life-or-death consequences. This responsibility is anxiety-producing for the student physician. The student must discipline himself or herself to deal with the underlying anxiety of clinical decisionmaking and its practical consequences.

Several researchers have commented on the reluctance of student physicians to engage in frank discussion with patients. Effective communication with patients requires that the student confront his or her own feelings about the patient and the illness, and the uncertainties and ambiguities that are an unavoidable feature of the treatment process.

Another source of resistance to open communication with patients derives from the concept of professional dominance. Most legitimated professions treat the knowledge base of the practitioner as a personal possession.[80] There is an underlying arrogance shared by all professions that sophisticated, technical knowledge cannot be easily understood by the layman. Medical knowledge is seen as part of the professional property of the physician. Sharing information with patients may be construed as undercutting the status and authority of the physician in the treatment relationship. For medical students first confronting the patient in clinical training, the need to adopt the role of physician also entails the assumption of authority over the patient. Restricting the patient's access to knowledge about his or her treatment may be a necessary expedient for the student physician who is unsure of his or her own status as a doctor.

Economic factors also argue against full and open communication with patients. Effective communication takes time. While a laboratory test or a physical examination may be charged to the patient, the time spent in discussing treatment with the patient is not immediately reflected in the patient's bill. For example, the current Blue Cross-Blue Shield reimbursement schedule actually pays the physician less for talking with the patient than for ordering a battery of laboratory tests. Physicians cannot be encouraged to talk more to their patients if economic incentives are absent. With the current interest in educating medical students in cost-containment and cost-effectiveness, students are confronted with economic realities of medical practice that may argue against open and effective communication with patients.

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[80] Tuohy, C.J. *Private government, property and professionalism.* CANADIAN JOURNAL OF POLITICAL SCIENCE, 9 (4), 668-681 (1976).

A final source of resistance lies in the organization of the hospital and clinical practice. In the busy office or clinic, students learn to process patients quickly and efficiently. Questions from the patient require time, and may extend the length of the clinical interview. All health care professionals must strike a balance between the desirability of answering patients' questions and the necessity of keeping up with a busy appointment schedule.[81] Medical students must learn to respond to the patient in a direct and open manner in the course of a brief interview.[82]

Despite these factors, the medical profession appears to have renewed its commitment to the humanistic ideals of medicine. Students, educators, and practitioners have come to recognize the physician-patient relationship as an essential element in the treatment process.[83] The programs and projects reviewed in this report testify to the value and efficacy of interpersonal-skills training in the education of student physicians.

Conclusions and Implications

The educational process of the physician begins with the decision to enter the medical profession and continues throughout the life of the individual. Attitudes, values, and beliefs acquired in the early social and educational experiences of the prospective physician influence his or her behavior in medical school and in mature professional practice. However, medical school is a powerful agent in the association process of physicians.

In examining the empirical literature dealing with the selection of students for admission to medical school, this writer found little evidence of significant and persistent differences among students based on race, ethnicity, or gender. Rather it appears that successful applicants to medical school have more in common with each other as medical students than as members of a particular minority group. This suggests that changes in medical school admission criteria based on the ascriptive characteristics of prospective applicants will result in only marginal changes in the attitudes and behavior of the new generation of physicians.

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[81] Zimmerman, B.N. *Human questions vs. human hurry.* AMERICAN JOURNAL OF NURSING, *80* (4) 719 (1980).

[82] Balint, E. and Novell, J.S. (eds.) SIX MINUTES FOR THE PATIENT. INTERACTIONS IN GENERAL PRACTICE CONSULTATION. London: Tavistock, 1973.

[83] Eisenberg, L. *What makes persons 'patients' and patients 'well'?* AMERICAN JOURNAL OF MEDICINE, 69 (2), 277-286 (1980).

The content of the educational experience in medical school appears to be the most salient factor in determining the quality of communication with patients. Intensive and comprehensive training in interviewing and interpersonal interaction between patients and student physicians appear to be effective in shaping student behavior in the direction of more open and nondirective communication. The training provided in medical school must have demonstrated relevance to the clinical management of the patient. Most of the studies reviewed in this report make the assumption that patients need the support, encouragement, and guidance of the physician in order to get well. The patient as a sick body is an inadequate metaphor for the treatment relationship, yet it is still prevalent as a background to students' clinical experience with patients. Most medical interventions are directed to the physical manipulation and chemical treatment of the body. This is particularly evident in the hospital setting. Student physicians learn first how to treat the patients' physical illness. If such interventions are the primary means of making patients well, then little attention need be paid to the social and emotional needs of patients. However, if the relationship between the ill person and his or her physician is a significant component of the treatment, the student physicians must be trained to develop the communication skills essential to establishing an effective relationship.

The underlying concern over the value and relevance of the social sciences to the training of medical students persists because of an ambivalent attitude about the clinical effects of the doctor-patient relationship in helping make sick people well. To date, the question of the effects of a "good" physician-patient relationship on the outcome of treatment has not been tested rigorously. Anecdotal evidence and subjective impressions of clinicians all suggest that communication with patients is important to their medical care. It is difficult to measure the effects in concrete terms.

In conclusion, it is evident that current practices that favor minimal exchange of information and limited communication between physicians and patients are developed and maintained as a result of professional socialization in medical school and clinical practice. Efforts to change the content of medical education at the undergraduate and graduate level and to reinforce learned behaviors in clinical practice are likely to be most effective in promoting open communication among physicians and patients.

Achieving Aesthetic Distance: Education for an Effective Doctor-Patient Relationship

Ruth Oratz*

Introduction—Medical Education Through the Pre-Clinical Years

In recent years, the traditional basis for relationships between health care providers and consumers has been challenged by changing notions of the individual's entitlement to health care, increased emphasis on patient autonomy, and demand for medical acountability. The doctrine of "informed consent" that has emerged in this context has implications for the nature of the doctor-patient relationship extending beyond its strict legal or ethical requirements for patient participation in medical decisionmaking about diagnostic and therapeutic procedures. Informed consent, in delineating the appropriate process by which medical decisions should be made, calls for a redefinition of the roles and responsibilities of doctors and patients and of the nature of their interaction and communication—striking a balance between the extremes of medical paternalism and total patient autonomy. These issues lead to an examination of the selection and education of future physicians and other health care professionals as they bear on patient-provider relationships and the possibility of meaningful informed consent.

Inasmuch as 40% of practicing physicians in 1990 will have been trained during the previous decade (Graduate Medical Education National Advisory Committee) a unique opportunity now exists for a timely and quantitatively significant influence on the selection and training of future physicians as well as on the near-term practice of medicine.

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This essay will address the topic of medical education, particularly the socialization of the medical student during the transition from pre-clinical to clinical training, in an attempt to understand how medical education shapes students' attitudes and affects future doctor-patient relationships as well as to speculate on possibilities for effectuating change in the medical school experience so that effective doctor-patient communication, mutual respect, and shared decisionmaking are facilitated. It draws upon the observations and analyses in the literature of medical sociology and medical education as well as the personal experiences of the writer, a fourth-year medical student in New York City.*

The goal of medical education is to give the practitioner a lifelong ability to maintain technical competence in the science of medicine and those interpersonal skills and insights into psychosocial and ethical issues that will permit the humanistic practice of medicine. This process—which begins in medical school, continues during the years of postgraduate residency training, and indeed endures throughout one's life in clinical medicine—requires a constant reconciliation of the tension between the science of medicine and the art of healing. In striving to obtain and preserve a dynamic equilibrium between these two apparently opposing forces, the trainee and professional must face certain stresses particular to medicine: the intellectual problem of medical uncertainty and the emotional problem of achieving aesthetic distance.

> Two basic types of uncertainty may be recognized. The first results from incomplete or imperfect mastery of available knowledge. No one can have at his command all skill and all knowledge of the lore of medicine. The second depends upon limitations in current medical knowledge. There are innumerable questions to which no physician, however well trained, can as yet provide answers. A third source of uncertainty dervies from the first two. This consists of difficulty in distinguishing between personal ignorance or ineptitude and the limitations of present medical knowledge.
>
> (Fox, *Training for Uncertainty*)

In the affective sphere the difficulty lies in finding a balance between "under-distancing," the evocation of raw emotion in too close a personal identification with the patient, and "over-distancing," excessive emotional detachment from the patient, in order to reach the appropriate median of "aesthetic distance."

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* Time and space constraints did not allow for wide reading surveys of all American medical schools. Much of the descriptive material related to students' perceptions of medical educators is drawn from this author's own experience and that of her classmates.

Although physicians must continually grapple with these problems in an extended and ongoing educational process, there are certain points at which abrupt discontinuities in experience magnify the urgency of these matters and present the student/physicians with particular challenges: entering medical school, the transition from the pre-clinical to the clinical years of medical school, beginning postgraduate residency, and the end of formal institutional training and the establishment of personal clinical careers in either the public or private sector.

At each of these critical junctures in his own personal professional development the physician must reassess and redefine his position with respect to the problems of medical uncertainty and emotional distance. Thus within a compressed period of four years, the novice is initiated into the medical establishment, must reconcile preconceived notions and fantasies concerning the profession with reality, and for most at the same time struggle with the problems of young adulthood; must make the transition from the textbook-oriented pre-clinical years to the highly personal patient-oriented clinical years; and must secure the postgraduate residency of choice and make the commitment to an even more intense period of several years, with real life-and-death decision responsibility.

The responses to the experiences during these years of professional training and socialization and the coping mechanisms used to adapt to the stresses they entail are critical in shaping attitudes regarding the doctor's role, the patient's role, their communication and relationship, and respective responsibilities in medical decisionmaking. It is therefore during these transition periods in medical education that directed educational policy might most effectively intervene to help shape doctors' attitudes and foster those that encourage better doctor-patient relationships.

The traditional medical school curriculum is divided into two phases: the pre-clinical years devoted to the mastery of the basic sciences, taught almost exclusively in lectures to the class "en masse" and in required laboratory exercises; and the clinical years, during which students rotate through a required set of clinical clerkships in internal medicine, pediatrics, surgery, psychiatry, and ob-gyn, and then participate in elective clinical rotations in ambulatory care, inpatient services and subinternships in various hospital departments.

The problems of the incoming student in coping with medical uncertainty are first encountered in the setting of the basic science curriculum. The massive workload and frequent comprehensive examinations of the pre-clinical years present the student with a potentially all-consuming task, evoke tremendous anxiety of failure, and isolate him within the circumscribed boundaries of lecture hall, laboratory, library, and dormitory. (Becker, *et al.*, Coombs and Boyle, Coombs and Stein) In their enthusiasm to convey the exponential growth in the knowledge at the frontiers of medical science, pre-clinical professors overwhelm the student with masses of data at a time when he is ill prepared to discriminate between essential and superfluous material. With often inadequate faculty guidance, and by virtue of their own inability to set limits and to assess which material is ultimately important for medical education, many students arbitrarily opt for the mechanism of "studying for the test." (Becker *et al.*) Although effective in eliminating some uncertainty and alleviating some of the fear of academic failure, this compromise at times leads to bitter resentment of the faculty. Moreover, students complain that the content of the course work in the basic sciences is largely irrelevant to the practice of clinical medicine, and that the caliber of teaching is far below standards expected of graduate education. (McGuire, Seagull) Many authors over the past two decades have identified as the foremost problem areas of medical students: academic pressure, competition, lack of leisure time, absence of close student-faculty relations, poor quality of teaching, and irrelevance of pre-clinical courses. (Edwards and Zimet, Rosenberg, Bloom, Funkenstein, Coombs and Boyle, Coombs and Stein)

> This situation, then: mutual idealism, high hopes, standards and expectations can be a dangerous setup for an increasing downward spiral of anger and mutual disappointment between students and faculty in the face of such unhappy realities as an unavoidable minimum of poorly taught courses and overwhelming amount of material to be mastered.
>
> (Seagull)

Even more disturbing is the net effect of these pressures on the student: a violent undermining of his self-image. (Rosenberg) Unable to cope with the demands of a rigorous academic agenda, inadequately supported by peers experiencing the same stresses, and put down by a largely unconcerned faculty, some students suffer serious losses in self-confidence and self-respect and fall into the "academic frustration syndrome." (Seagull, Grover and Tessier) The majority of students will eventually weather these stormy difficulties without overt psychiatric problems or impairment of function, but it is disturbing to see how many medical students are seriously impaired.

The Transition to the Clinical Years

Preliminary Patient Contact. When the student gets down to the actual business of becoming a doctor, he struggles with medical uncertainty with a sense of urgency not present during the pre-clinical years. Despite recent innovations in medical school curricula, there remains a jarring discontinuity between the basic sciences and clinical clerkships, between the lecture hall and hospital ward.

Much student-patient contact in the pre-clinical years occurs in a carefully designed, almost contrived, manner in order to eliminate threatening or anxiety-provoking scenarios for both students and patients. The pre-clinical selectives offered at one Eastern medical school typify some of these encounters. Students may participate in the "Family Life Program" in which they are assigned to follow a pregnant woman through the third trimester of her pregnancy, assist at the delivery of the baby, and then see mother and child for well-baby visits in the pediatric primary care clinic. Another course permits students to follow a patient with terminal illness during periods of outpatient care and hospitalization. In both programs students are encouraged to become involved with patients in personal relationships and to consider broader psychosocial and ethical issues, rather than just strictly medical ones, in the patient's management.

The students' other major exposure to patients occurs in the context of the "Human Behavior" or first-year psychiatry course. Students observe and conduct interviews with patients in both one-on-one and group settings, under supervision of psychiatrists, clinical psychologists, and social workers, in order to develop some history-taking skill and some insight into how patients cope with illness—acute, chronic, medical, and psychiatric.

The culmination of the pre-clinical student-patient interaction takes place in the physical diagnosis course immediately prior to the third-year clinical clerkships. Most educators recognize this course as a unique opportunity to formally instruct students in the fundamental skills required to obtain a medical history and perform a physical exam, and most medical schools succeed in imparting these basics to their students. However, there is wide variation in the structure of these courses—with respect to time allotment, lecture versus patient-contact hours, student-patient and student-instructor ratios, and kind of patient population from which to select participants. Moreover, as many of the physical diagnosis instructors are very busy, indeed burdened clinicians, and as their ability to teach almost completely ignorant students may depend more on their personalities than on their competence as physicians, the quality of teaching and students' subjective experiences in this course may suffer.

Although all these experiences help alleviate some of the initial anxiety over patient contact, in many instances they fall short of optimal preparation for the clinical encounters on the hospital wards. Neither the young, healthy pregnant woman, nor the terminally ill patient, nor the model patient in a physical diagnosis course provides students with realistic expectations of the ward experience. And by virtue of their lack of medical expertise and role as observers, pre-clinical students have limited input in decisions related to medical management.

As a consequence they carry no responsibility for outcome of diagnostic or therapeutic intervention. However, an ever-present buried anxiety concerning the ultimate assumption of medical responsibility preoccupies many students. It is perhaps for this reason that many have gnawing doubts about their ability to cope with the transition to the clinical experience, where they will encounter the first real patient.

Self-Image and the Medical Hierarchy. Gradually students evolve from passive observers to more active doctors-in-training. (Becker *et al.*, Lief) One study reports that while 70% of first-year students perceived themselves primarily as students, by the fourth year 80% saw themselves as doctors. (McGuire) While fostering a change in self-perception, the initial exposure to and then participation in clinical practice during the clerkship rotations challenges some students' preconceptions about medicine—perhaps shattering some illusions.

For most third-year students, the first day on the wards holds an almost ceremonial significance, marking the initiation of a series of "rites de passage" in the process of medical socialization. The student's emphasis on adherence to an unofficial dress code (white pants with tourniquet tied to the belt and stethoscope slung around the neck, a name tag with its glaring omission of those two weighty initials: MD) and the use of special language in (which patients become "cases," "hits," "gomers," or "crocks," and are "well-known" if they've been previously admitted; they have "MIs" instead of heart attacks, "metastatic disease" instead of cancer, and "CVAs" instead of strokes and "abuse ETOH" instead of drink alcohol) constitute the superficial reflections of a more profound concern with acceptance into the society of medicine.

The student rapidly learns that the medical world is organized in a strictly hierarchical fashion. Although presenting an exaggerated caricature, one student allusion to the medieval feudal system captures some element of truth:

> The chief of staff is king, the attending physicians his nobles with the chief medical resident as knight in shining armor; the residents are vassals, the interns, serfs, and the students—the ground upon which they all walk.

There is, though, a more relevant analogy between the hierarchies of medicine and the feudal system: Men are linked to one another in a long chain of progressive and mutual responsibilities, each expecting his carefully designed assignments within a limited repertoire of activities, and each responsible *to* the man above him and responsible *for* the one beneath.

The asymmetry with respect to knowledge and experience among individuals should be overridden by the interdependent nature of their work on the health care team. The student and junior house officer trade a certain amount of autonomy and perform most of the routine chores of medical work in return for instruction and guidance from clinical faculty.

> [However] since the student, by definition, is the lowest man in this system and has the least of those things which are the equipment of the practicing physicians, he is also by definition unable to tell what kinds of training he should be getting. As the system is organized, he has no legitimate grounds for expressing discontent with his situation, since the situation is defined by men more experienced and more capable of exercising responsibility than he.
>
> (Becker *et al.*)

Moreover, as the student begins to assume greater responsibility in his contact with patients, he realizes his identity within the professional hierarchy does not necessarily correspond to the image of "doctor" that patients and society have. The current demands for increased public accountability of all professionals, particularly doctors, and external challenges to the practitioner's maintenance of a privileged position of self-selection and self-regulation further confound the student's attempts to become assimilated into medical society.

The First Patient. The first shock of the clinical experience is that *the patients are sick*. Until this time patients were nameless, faceless paragraphs on the printed page, presented with textbook signs and symptoms of classically described diseases. "On the wards," however, the patient is a feeble, cachectic, white-haired gentleman (vaguely resembling someone's grandfather) who has lost his appetite, his memory, his curiosity about and desire to live. Or an 18-year-old unsophisticated, uneducated child who has taken a dangerous overdose of aspirin in the second trimester of her third pregnancy. Or a 35-year-old obstreperous, uncooperative alcoholic who is vomiting blood and bleeding to death from the consequences of his alcoholism. Moreover, "on the wards" the student is struck with sensual onslaught of *morbidity*: the sight of these patients in hospital beds surrounded by and attached to needles, tubes, bottles, dials, computerized monitors—all the trappings of technological medicine; the sounds of anxious screams, painful moans; the stench of unwashed feet, stale urine, feces, pus, sputum, blood. "On the wards" it becomes the student's responsibility to collect, inspect, and analyze these body fluids that may hold the key to a tough diagnosis. And finally, the student must learn how to "work-up" a patient: to listen to his or her story, ask appropriate questions, sift through the details and vagaries and distill the essence of *the pertinent medical history*; to examine the patient, peer through the opthalmoscope to the back of the eye-grounds, auscultate the chest for breathsounds and heartsounds, palpate the abdomen, examine genitalia, do pelvic and rectal exams—in sum, to touch and invade the patient's personal and physical integrity in a rough attempt to ascertain *the pertinent physical findings*.

Not only is he expected to make medical sense out of this assemblage of sights, sounds, smells, feelings, but the medical clerk must be prepared at all times to give a learned discourse on the etiologies, physiologic mechanisms, and pathologic manifestations of the disease, as well as to detail the multitude of possible causes of the patient's condition.

> There are at least two reasons why a student may "miss" an important clinical sign, or feel uncertain about its presence or absence. On the one hand, his oversight, or doubt may be largely attributable to lack of knowledge of skill on his part. . . .
>
> On the other hand, missing a spleen, for example, or "not being sure you hear a murmur" is sometimes more the "fault of the field" (as one student puts it) than your "own fault." That is, given the limitations in current medical knowledge and technique, the enlargement of a spleen may be too slight, the sound of a murmur too subtle, for "even the experts to agree upon it."
>
> (Fox, *Training for Uncertainty*)

Moreover, many students quickly become sensitized to the importance of personal interactions with physician-teachers and the impact upon the often very subjective and seemingly arbitrary evaluation of their performance.

While morbidity generates anxiety for the medical student, mortality is exquisitely threatening. The first patient dies. Although Fox and others have pointed out that medical students are prepared in the anatomy lab and at the autopsy table to deal with death (Lief and Fox), the death of the first patient is for many an emotion-laden experience. This confrontation with mortality tests the student's ability to maintain anesthetic distance, "detached concern." Some turn to religious or cultural explanations for solace, others await the post-mortem report (if an autopsy is to be performed) in order to intellectualize reasons for the patient's death, and still others are left with their own pain and anxiety over questions unanswered: Why did the patient die? Did we know he was going to die? Did the patient himself know? Did we do anything that might have prevented, postponed, or hastened the patient's death? Did we miss something? Did his family and friends know he was going to die? Did anyone talk to the patient, his family, his friends? Can we explain, within the limits of current medical knowledge, what happened?

The balance that most practitioners ultimately strike between cool, efficient, scientific expertise and humane, empathic communication in caring for patients does not come readily to the novice. Many students have difficulty feeling authentic with patients, but wish to bring to the bedside the kind of confident optimism they believe most patients expect. When asked to demonstrate how he would introduce himself to a patient, one student responded, "I am, perhaps, a medical student." (Werner and Korsch)

In the highly technological, often impersonal setting of the contemporary American hospital, the student's vulnerability, identification with the patient, and need for human interaction especially lead to an almost instinctual drive to underdistance. Martha Weinman Lear's widely acclaimed account of her physician-husband's experience as a cardiac patient poignantly describes this situation:

> Then, dimly, he felt himself being lifted onto a stretcher, sensed noise and light and a sudden commotion about him. They were giving him nasal oxygen, taking his pulse, taking his blood pressure, starting an intravenous, getting a cardiogram—the total force of modern emergency care suddenly mobilized; a team clicking away with the impersonality of an overwhelmingly efficient machine.
>
> He understood that at this moment he was no more than a body with pathology. They were not treating a person, they were treating an acute coronary case in severe shock. They were racing very quickly, against time. He himself has run this race so often, working in just this detached silent way on nameless, faceless bodies with pathologies. He did not resent the impersonality. He simply noted it. But one of the medical team, a young woman who was taking his blood pressure, seemed concerned about him. She patted him on the shoulder. She said, "How do you feel?" It was the only departure from this cool efficiency, and he felt achingly grateful for it. Ah, he thought in some fogged corner of his brain, she must be a medical student. She hasn't yet learned to depersonalize. She will. We all die. What a pity.

As the year of rotating clerkships continues, the student is compelled to assimilate personally consistent sets of attitudes and behavioral responses to the anxiety-provoking issues related to morbidity and mortality. A variety of coping mechanisms, along with continued teaching—both formal and informal, direct and indirect—facilitate this maturation process. In becoming more experienced in and accustomed to interviewing and examining patients, and in attaining greater medical knowledge, technical skill, and personal confidence, many students gradually begin to achieve aesthetic distance.

Responses to the Challenge: Coping Mechanisms in Socialization

Intellectualization—disease orientation. Not uncommonly, medical students, house officers, and attendings rely on excessive emotional detachment and resort to a highly intellectual approach to their roles as health care providers by focusing on illness, regarding it as a set of signs, symptoms, laboratory values, and radiological findings in direct contradiction of the fact that:

> Illness is usually *not* an isolated event in a localized part of the body, but is a change in a complex integrated human being who lives and works in a particular social and family setting, who has a biological—psychological social history.
>
> (Mills)

The depersonalization of the patient in the doctor's eyes frees him from a threatening emotional attachment to the sick individual and, by denying the human implications of sickness and death, protects him from those associations. The individual physician may be accused of callousness, while the profession at large is indicted for adopting a "disease orientation" rather than a "patient orientation." However, because its substantive contents are entrenched within contemporary medical scientific models, and because physicians must ultimately assume intellectual responsibility for their diagnostic and therapeutic actions, the "disease orientation" is rationalized by many as the most objective and most efficient approach to the case. It pervades critical practice and many of the occupational rituals of institutional medicine.

Occupational rituals. In most American teaching hospitals, rounds are made daily on all patients. House officers and students present new admissions and report follow-ups on other patients to the attending, who then directs discussion about relevant medical issues and advises on the formulation of intervention plans. Ideally these rounds are to be conducted at the bedside in order to (1) ensure that doctors communicate directly with patients and obtain accurate firsthand knowledlge of the patient's history and physical status and (2) provide students with the opportunity to observe the disease process and participate in primary doctor-patient contact under the guidance of an experienced professional. Osler stressed the importance of bedside rounds in medical education:

> In what may be called the natural method of teaching, the student begins with the patient, continues with the patient and ends his study with the patient, using books and lectures as tools, as means to an end. . . . For the junior student in medicine and surgery it is a safe rule to

> have no teaching without the patient for a text, and the best teaching is that taught by the patient himself.
>
> (Osler)

Unfortunately, Dr. Osler's method has been largely ignored or grossly distorted in the actual conduct of daily attending rounds. In a recent study of ward rounds in a major teaching hospital, the authors found that

> of a total of 341 minutes [video] taped, 55 minutes (16%) of the time were actually spent at the bedside or with a patient present; and for at least one-half of that 55 minutes the presence of the patient was not actually necessary to the discussion. *In fact, most rounds tended to take place in the corridor, an area ill-suited to discussion of any type.*
>
> (Collins *et al.*, emphasis added)

On rounds the student learns to recite a highly formalized, impersonal rendition of the case: chief complaint, history of present illness, past medical history, family history, social history, review of symptoms, physical exam, laboratory data, summary, and formulation. He is rewarded for producing an exhaustive list of possible diagnoses (the differential diagnosis), preferably with references from the medical scientific literature. Students rapidly develop new competitive strategies for citing the most recent publications and most esoteric diagnoses in hoping to impress the attending with their brilliance. Instead of addressing how best to manage the combination of medical, psychological, and social problems involved in the patient's hospitalization, discussions on rounds tend to become miniconferences on pathophysiology. Although there is a real value in reiterating fundamentals of disease causation and pathophysiological principles, many commentators have noted that daily rounds are hardly the forum for such discussion to the exclusion of broader concerns in patient management.

> Such a lack of attention to the patient on rounds can have the unfortunate consequence of reducing in the eyes of the student the individuality of the patient and his particular problems and of minimizing the value of the information that derives directly from the patient in the course of interview and observation. It encourages callous attitudes as well as the deplorable tendency to overemphasize the laboratory work-up.
>
> (Engel)

The role of the attending physician and the goals of rounds themselves in the contemporary teaching setting are often poorly defined. Professionally overburdened faculty members are often assigned the impossible task of performing simultaneously as health care provider, researcher, expert consultant, and clinical teacher. Moreover, some too often are people who themselves never really have seen a problem, which further impairs their efficacy as positive role models for doctors in training.

When the discussion returns to the diagnosis and management of the individual patient, as indeed it must, having dispensed with the problem of emotional distance by maintaining excessive detachment, the team must now grapple with the problem of medical uncertainty. Here students observe the defense mechanisms of their mentors on yet another plane. Faced with the task of deciding on a diagnosis and subsequent therapy, physicians again lean on various cognitive and affective crutches.

First, they draw on their own personal funds of medical knowledge. If unable to solve the problem with the given information, more laboratory studies may be requested. Many attendings choose not to discuss topics in which they are not well versed. As one attending states: "I never discuss what I feel uncertain about. I try to limit my comments to the aspects of scientific medicine that I feel expert in." (Linfors and Nelson) If personal knowledge is exhausted, expert consultants may be called in. After that, the physician will turn to the medical textbooks and papers that delineate the boundaries of known medical science. Martha Weinman Lear explains the role of the literature in medical decisionmaking at a time when doctors were puzzled about her husband's condition:

> But now the professors said simply, No. Autoimmune reactions occurred months after surgery; this was well documented in the literature. But years after surgery? No; that was unheard of in the literature. *If it did not appear in The Literature, it did not exist.*

Finally, if there is no objection, scientific explanation of the patient's condition, the physician must rely on his feelings, his intuitive sense, his "clinical experience." Students quickly learn that clinical experience is directly related to seniority and carries as much respective authority in decisionmaking as the medical literature does.

The problems related to resolving ambiguity about what to do next, indecisiveness, and lack of unanimity on the part of members of the health care team are extensive. Although several lines of action (or inaction) are possible, the invocation of clinical experience as the authoritative solution to the problems of diagnosis and management, although not necessarily ideal medicine, is one means of ending debate on rounds. There are times, however, when even the attending feels uncomfortable claiming previous experience with a similar situation or when the team refuses to blindly accept his dogmatic pronouncement; closure cannot be reached. In these cases, the decision is made not to decide—and the patient is strung along through a series of "work-ups" until a consensus is eventually achieved.

In addition to the experiences of daily ward rounds, students learn how the profession copes with uncertainty and achieving balance between detachment and concern through two other occupational rituals: Grand Rounds and Morbidity and Mortality Conference. Grand Rounds is a weekly meeting of the entire department of medicine including attendings, house officers, and students. A recognized authority is called on to discuss an interesting aspect of a recent case or is presented with a difficult diagnostic problem in the form of a CPC (clinico-pathological conference), in a kind of "stump the expert game." He is asked to analyze the case, referring to the literature as well as his own clinical experience, and to make the diagnosis. Most often he is correct; his diagnosis correlates with the pathologists' and the exercise serves as a confirmation of the scientific truth and efficacy of contemporary medicine.

If Grand Rounds is a public, self-congratulatory back-pat, then Morbidity and Mortality Conference is a public self-flagellation. At this weekly conference a case is presented in which medicine failed, when the patient wrongly suffered or died—either because of insufficiency of medical science or the personal limitations of the individuals involved in the case.

> As a form of ceremonial apology, [Morbidity and Mortality Conference] allows a proper and professional expression of guilt and teaches residents that some failure is an inevitable, unfortunate and intractable fact of professional life.
>
> (Bosk)

Aside from these cognitive adaptations to the stresses of medical uncertainty and achieving aesthetic distance, physicians and medical students employ affective mechanisms in their defenses. Perhaps the most widely used of these is humor. In denying the seriousness of an occasion and transforming an upsetting experience into a pleasant one this brand of counterphobic, "gallows" humor works to relieve tension and reduce anxiety. It is particularly effective in minimizing discomfort with sexuality and pain, the sense of helplessness in the face of terminal illness and death, or the humilation over errors in judgment or medical/surgical intervention.

At the other end of the emotional spectrum lies an almost morbid attachment to disease known as medical student hypochondriasis: "the development of either symptoms of or hypochondriachal anxiety about the disease being studied by the student." (Woods, *et al.*) More than three-quarters of medical students interviewed confirmed that they suffered from MSH at some point during their training. This response reflects the student's identification with the patient during a time when his own sense of self is damaged. As one student wryly noted, "We are now in the process of contracting the diseases we are studying in order to develop emotional immunity to them." (Fox, HUMAN CONDITION—A LECTURE) Moreover, MSH may even contribute to some facilitation of learning and retention of knowledge with respect to the disease in question. (Woods *et al.*)

Idealism and Cynicism—An Analysis of the Empirical Literature

Situational versus Psychosocial Factors. The outcome of this medical educational process during the transition from the pre-clinical to the clinical years is characterized in the empirical literature of medical socialization as a shift in medical students' attitudes from idealism to cynicism. (Becker and Geer; Eron; Fox, *Comparative View;* Merton) Indeed, one author offers the tongue-in-cheek suggestion that the two traditional phases of the medical school program be renamed the "pre-cynical" and "cynical years." (McGuire) Medical sociologists and educators generally have two explanations for the dramatic change in students' outlooks, arguing on the one hand that the problem is fundamentally situational—the traumatic and dehumanizing experiences of medical school precipitate discontent and disillusionment—and on the other hand that underlying psychosocial factors within medical students account for the inevitable development of cynicism. Attempts to collect empirical data in support of either of these contentions, though well founded, are by virtue of the subjective nature of the subject fraught with problems.

Eron, in one of the earliest and most frequently quoted empirical reports, tested the hypothesis that increased levels of cynicism and decreased levels of idealism (humanitarianism) are related to the anxiety engendered in medical students during their training. In a longitudinal study comparing first-year and fourth-year medical students with a control group of students in another field, he measured cynicism, humanitarianism, and anxiety with a battery of questionnaire-type psychological tests. Cynicism was defined as "a contemptuous disbelief in man's sincerity of motives or rectitude of conduct, characterized by the conviction that human conduct is suggested or directed by self-interest or self-indulgence"; humanitarianism was defined as "a regard for the interests of mankind, benevolence, philanthropy." He found senior students were clearly more cynical than freshmen and that by the time medical students became seniors there was a definite interaction among humanitarianism, cynicism, and anxiety, although while they were still in the early part of their freshman year the effect was random.

Senior students showed a correlation between increased cynicism and decreased humanitarianism—and increased cynicism was directly related to increased anxiety. Studies by Christie and Merton and by Gordon and Mensch corroborated these findings. Furthermore, Eron, and later, Parker, did not find comparable increases in levels of cynicism among students in nursing and law, ruling out age-related effects.

Gray and Newman disclosed that students with high levels of cynicism performed poorly in medical school in comparison with classmates with lower cynicism scores.

In a more recent empirical study, Rosenberg designed an experiment to "trace the process of attitude change, to chart the development of professional role behavior, and to provide an ongoing and immediate critical evaluation of the medical school curriculum as feedback for a faculty planning curriculum change." She found that students' initial optimism and enthusiasm about medicine turned to resentment and sarcasm, and attributes this attitude shift to the anxiety evoked by traumatic experiences of medical school, stress over academic workload, and what she perceives as an undermining of the student's self-image.

A 1975 survey at the University of Colorado Medical School identified several problem areas in which medical students indicated they had experienced significant problems or concerns. (Edwards and Zimet) Academic pressures related to exams, quantity of material to be learned, competition, and lack of time for recreation, family, and friends were most commonly cited by students. The authors concluded that situational factors account for a large proportion of the etiologic components in medical student impairment.

Fox has also emphasized the predominance of situational stress of medical school over pre-existing personality traits in causing the attitude shift from idealism to cynicism. She points out that attitudes and behavior are not necessarily correlated and need to be more carefully studied, and that cynicism may be a form of adaptive or defense mechanism that is self-protective but not necessarily acted out.

Most authors agree that the shift from idealism to cynicism during medical training is largely situational. However, some have stressed the importance of personalities and psychosocial backgrounds of the students themselves prior to entering medical school as contributing to the development of these attitude changes. Despite the recent acceptance into medical school of increasing numbers of women, minorities, and older students, the average entering class remains composed primarily of white, middle-class males in their early twenties who "share the common values and goals of one of the most highly organized and conformist groups in our society—the profession of medicine." (McGuire) Despite a certain heterogeneity of background and experience,

> [t]he end result is that these thousands of people all become much the same, but remain different; they all

> assume similar values, but continue to behave according to what they were before medical school, what happened to them while in training, and what experiences they have had since. Each becomes a walking compromise of culture, personal experience, profession and heredity.
>
> (McGuire)

Several authors have examined the issue of psychopathology among medical students and have tried to distinguish between impairments resulting from the process of medical education and those inherent in the personality structures of the students. Lief describes medical students as

> possessing an obsessive-compulsive personality tending to strive for mastery, control, thoroughness, safety, and self-restraint. They put intellectual matters above emotions, security above pleasure, service to others above self-service (at least consciously), exactitude above fantasy.

He concludes that medical education in and of itself is not entirely responsible for generating the personality characteristics and producing inveterate cynics—but the students are bringing some of these problems with them to medical school.

Although most students concur that medical school is a stressful experience, and cite academic pressure and interpersonal competition (Edwards and Zimet, Rosenberg, Merton *et al.*) as primary concerns, most also succeed in adapting to these strains. Others respond less successfully and may show evidence of impairment, including somatic symptom formation, depression, anxiety, lowered self-esteem, academic difficulty, or family problems. (Lief *et al.*, Kimball, Miller and Erwin, Sazlow, Thomas)

Women, minority students, and those from lower socioeconomic groups—those who do not fit the stereotypic mold of the average white, middle-class medical student—were found by Coburn and Jovaisas to experience greater difficulty in adapting to the emotional tension experienced in medical school. This may be related to the dearth of adequate role models for such students—as neither women nor minorities are represented to a large degree among the ranks of attending physicians. Furthermore, in having to conform to the standard cultural model of medical student and later doctor in order to successfully socialize into medical society, these students are especially vulnerable to challenges that might result in a lowered self-esteem and an inability to develop a strong sense of identity as a competent and confident physician. Women risk tremendous conflict over academic achievement and career success versus femininity and personal satisfaction—while racial minorities face a tension of assimilation versus commitment and a loss of cultural identity.

(Campbell, Notman)

The situational stress of medical school is far from a new problem. In 1936 Strecker and his colleagues revealed in *Psychiatric Studies in Medical Education* that 46.5% of the senior medical school class were "unstable" or possessed "neurotic reactions which would burden them throughout their life or which in all probability would impair their optimal efficiency." (Strecker *et al.*) They concluded that while most students were inherently stable and could withstand the emotional stress encountered in medical schools, those with neurotic trends or frank psychiatric pathology "are facing a serious hazard in attempting medical education."

Most recently Adsett reported in 1968 that 13% of medical students at the University of Oklahoma obtained psychological counseling for problems largely related to emotional conflicts. Hunter and Schwartzman found that 40% of the students treated for psychological problems at McGill University Medical School had histories of psychiatric disorders predating entrance into medical school. Adsett confirms that among those students he identified as requiring psychiatric intervention a large number were suffering from reactivation of long-standing latent intrapsychic conflicts.

The defense mechanisms most commonly adopted by students—intellectualization and repression of affect—though encouraged and indeed rewarded by teachers and other authority figures, may be least effective for coping with the stress of medical school and particularly with the transition from the basic sciences to the clinical interaction with patients. (Keniston)

The Selection Process. It seems that the process used by most medical school admissions committees are designed to select *for*, rather than *against*, applicants who are likely to rely on these maladaptive defense mechanisms. Selection policies reflect a long-standing preference for students with superior academic performance, as measured by high MCAT and GPA scores, and special technical competence in the natural sciences. While these students tend to succeed during the basic science years, it is not clear that their previous academic excellence is predictive of high levels of performance during the clinical years of training—particularly with respect to their abilities to understand and cope with patients' psychological and social needs. On the other hand, students possessing high levels of maturity, nonacademic achievement, motivation, and rapport were two to three times as likely to succeed in the clerkship years than peers with only high undergraduate GPAs. (Murden *et al.*) Moreover, another study revealed that students with nonscience undergraduate backgrounds scored higher on the behavioral science subsection of the NBME Part I, and performed as well as undergraduate science majors in their clinical notations. (Dickman *et al.*)

Recent studies have revealed that policies considering both cognitive and noncognitive abilities of applicants have greater predictive value for future success in medical school and clinical practice than those relying on cognitive measures alone. Finally, clear differences in the behavior and performance of women and ethnic minorities have not been demonstrated and the long-term effect on health care delivery of admitting greater numbers of these groups remains uncertain.Nonetheless, the data, although preliminary, suggest that traditional selection criteria may be eliminating students who might be better predisposed to a more effective practice of humanistic medicine.

Long-Term and Near-Term Effects. The long-term effect and permanence of attitudes developed during medical training have not been adequately delineated. Gray and his colleagues analyzed physicians' attitudes of cynicism and humanitarianism before and after entering medical practice. They corroborated prior studies that demonstrated increased cynicism in medical students but found that physicians' attitudes of cynicism were significantly lower after entering medical practice. Their conclusion is that cynicism among medical students is fundamentally situational and has no long-term effect on physicians' future practices.

Reinhardt and Gray confirmed that higher levels of cynicism correlate with aspects of medical training but reported that physicians with higher cynicism scores were more likely to choose careers in specialties that involved less personal interaction.

Simon, on the other hand, writes

> The transformation of an individual from a broadly oriented, humanistically inclined yet relatively uncritical student into a critical, analytic, logical and scientifically oriented physician is one of the aspects of professionalization occurring in medical school. The cynicism which occurs simultaneously is regretted by many, but this loss of idealism is considered to be of minor importance in comparison with the gains in other directions.

Others have also raised the possibility that stressful experiences that demand significant adaptations are potentially beneficial to an individual's maturation. (Rahe and Arthur)

Rezler claims that attitudes are highly resistant to change unless supported and reinforced by the total environment. She suggests that medical schools might select certain personality types to enter specific training programs in appropriately oriented clinical specialties.

Despite an apparent consensus among observers that medical students undergo a shift in attitudes from idealism to cynicism, the empirical literature is confusing and at times contradictory with respect to the causes of this process. The interactions between pre-existing psychosocial characteristics, selection policies that favor certain intellectual and personality types, and the experience of medical school are undoubtedly complex. Moreover, there are difficulties in interpreting empirical studies designed to analyze these issues. Most studies are seriously limited in scope and design; few are prospective and most are uncontrolled. Definitions of such terms as "cynicism," "humanitarianism," and "maturity" vary among investigators. Techniques for measuring attitudes or scoring personality traits are inexact; the often used interview or questionnaire format is hardly standardized and the interpretation of data obtained from either is overlaid with the personal biases and social cultural values of the investigators themselves. Finally, no studies view the problem of increasing cynicism and discontent among medical students within the broader social-economic-cultural framework of the contemporary practice of medicine. A brief discussion of this perspective is warranted.

Although most students and practitioners assert that altruism is a driving force behind their choice of medicine as a career, their claims must be understood within the context of the strong cultural value placed on making precisely such assertions. Leserman is particularly wary of such pretensions, and writes

> The data suggest that incoming medical students are concerned with helping people but not necessarily through political means, committed to some geographic and specialty areas of patient need, choosing medicine for reasons other than economic rewards but not opposed to physicians' large income and status, and somewhat unaware of discrimination toward women physicians and patients.

It is largely unacceptable for students and medical professionals to talk frankly about the importance of financial considerations in their selection of medical careers. However, most students enter medical school with expectations for high social status, economic security, and success—values inculcated by society, parents, teachers, and peers often long before the student is in pre-medical undergraduate studies. For achievement-oriented, upwardly mobile young adults, the difficulties entailed in realizing such goals, and the possibility that they may not indeed be attained might contribute to increased levels of anxiety and cynicism.

First, the high cost of medical education (with annual tuition currently ranging from $8,000 to $15,000) and diminishing loan and financial aid resources demand that students incur substantial personal debt or that their families sacrifice significant and often needed funds. Few students are unconcerned about repaying this large sum. In addition the opportunity cost of spending many years in medical school and postgraduate residency training with little or no income, especially when peers complete their educations sooner and begin earning double or triple the medical initiate's salary in responsible and prestigious jobs, breeds resentment and may lead some, particularly those with less than a serious "calling," to question the soundness of their choice of profession. Graduating medical students also realize that their education does not provide them with the same transferability of skills that others in liberal studies professions might enjoy. Moreover, medical education and residency training often force young adults, and particularly young women, to forego or postpone important personal goals—including marriage and childbearing—which can also lead to anxiety, disappointment, and cynicism over one's career choice.

Uncertainties about the future organization of health care delivery and the nature of medical practice in this country are also distressing to some students. In light of increasing prospects for external regulation of the profession, both direct and indirect, and the relative decline in physicians' socioeconomic status, some students perceive a gloomier future than they originally expected. Many see the expanding supply of MDs, the diminishing job opportunities, and the shift from fee-for-service to fixed-income salaries as increasing limits on doctors' personal freedom of choice about location and type of practice, and as virtually precluding the establishment of a solo private practice in a metropolitan area. Although for some students these particular issues are not of great significance, for many they remain real concerns and contribute to the development of disillusioned, cynical attitudes as graduation from medical school and the assumption of real-world responsibilities draw near.

Although the impact of the socialization experience during medical school on the long-term practice of medicine and on the nature of future relationships between doctors and patients is uncertain, the immediate effects are more readily identified and may be of no less importance. Many authors have studied the influence of underlying personality structures on choice of specialty. It has been suggested that individuals who tend to be less authoritarian, dogmatic, and cynical gravitate towards fields involving high levels of interaction with patients, such as radiology or pathology. (Reinhardt and Gray) Students' reactions to situational experiences on the various specialty rotations, especially with respect to encounters with potential role models, may affect career decisions. Another factor contributing to these decisions is the image that the specialty conveys, in light of its perceived status within the profession and in the public's view.

The response to the medical school experience, and the development of disillusioned, cynical attitudes among students, may spill over into behavior during the residency training period regardless of specialty. Despite the fact that attitudes may later change, their persistence and prevalence among house officers may have a net detrimental effect on doctor-patient relationships, especially since large numbers of patients encounter house officers as their primary physicians, particularly in municipal hospitals.

Recommendations

Given public concern over the delivery of health care and over doctor-patient relationships, and the great number of recently trained physicians who will be joining the pool of practicing doctors, an examination of the process of medical education and of how to improve that training is timely if not imperative. Indeed, the long lead time between the initiation of new curricular programs and any evidence of their effects mean such efforts must be expedited if they are to have significant impact by the end of the next decade. Several possibilities exist for positive intervention—most notably during the transition periods in medical education: the start of medical school and the transition from the pre-clinical to the clinical years.

Entering Medical School. As mentioned earlier, there has been a recent surge of interest in admissions criteria, with attempts to predict which intellectual and nonintellectual characteristics of premedical students may contribute to excellence in clinical performance. Although some empirical work has already borne fruit, there is still a great deal of information to be collected. While awaiting further objective information regarding changes in the selection process, it does not seem unreasonable to propose certain policy suggestions based on experience to date.

Since many of the difficulties encountered by students during medical school seem to take place in the affective arena, it's quite likely that students who are somewhat older than the average college graduate, who have had time to secure their own adult identities and gain some life experience, will be better equipped to cope with the stress of medical school and to bring greater humanistic insight to their interactions with patients. Although imposing a minimum age of admission would be arbitrary and nonsensical, greater attention to personal maturity and consideration of older applicants may prove rewarding. Similarly, increased emphasis on other nonintellectual factors—basic personality structures, coping mechanisms, and the quality of interpersonal relationships—seems to select students who ultimately perform as well as if not better than those who excel only in academic pursuits. The enormous value currently placed on scholastic excellence alone may only aggravate problems of competition.

Problems related to motivations behind choosing medicine as a career find their base in much broader social, political, and economic factors, and therefore may be beyond the control of medical school admissions committees. Nonetheless, relieving some of the strains of financing medical education could alleviate some student anxiety, contribute to a greater sense of security, and avoid the emergence of one source of disillusionment and resentment. The sluggish economy and present cutbacks on student loans, financial aid, and work-study programs are disheartening. It is unlikely that free, or even reasonably well subsidized, higher education will be attained in the near future. Yet medical school administrations should display greater interest in and assume more responsibility for ensuring that students meet their financial obligations.

The Transition to the Clinical Years. Attempts to prepare students for the transition from lecture hall to hospital ward appear to have become more prevalent. Such programs deserve more attention, time, and energy. Their objectives may be identified in three distinct categories: early patient contact, faculty guidance and emotional support, and the teaching of medical ethics and interpersonal skills.

Early patient contact. Although many schools have already recognized the value of patient contact early in the preclinical years, most experiences fall short of their potential. Formal teaching sessions, where students first attend lectures and read material addressing issues in doctor-patient relationships, have proved useful. (Pollock and Manning) Observation of experienced clinicians' interactions with patients might be followed by actual student participation in interviews under adequate supervision. Ideally, students would begin with relatively healthy, well-adjusted patients and gradually progress to increasingly complicated medical and psychosocial situations. In this manner students would be able to slowly develop skills in interpersonal communication and start to deal with problems of medical uncertainty and achieving aesthetic distance, free of anxiety over responsibility for clinical intervention and evaluation of their performance. Informal discussion with supervisors after the patient contact could reinforce positive characteristics in the student's approach and constructively criticize those that were less useful. Such experiences can dispel students' illusions about clinical practice before they are placed in the threatening position as "most vulnerable player on the health care team." (Merenstein and Coulehan, Schimpfhauser *et al.*)

Faculty guidance and emotional support. Higher teacher-student ratios in the courses involving patient contact are desirable, not only to supervise the acquisition of technical skills required to perform a physical examination but also to advise and guide students in developing effective communication skills. Furthermore, closer contact with both clinical and nonclinical faculty in informal settings could lessen student resentment of faculty and provide appropriate role models.

In addition to encouraging more satisfying relationships with faculty, medical schools should provide students with extensive networks of emotional support for dealing with the myriad stresses of medical training. Upperclassmen and house officers might participate in informal discussion groups or be encouraged to offer time to individuals who need assistance adjusting to particular concerns. Students should be encouraged to air their anxieties before they learn to repress all feelings or adopt maladaptive defense mechanisms that eventually lead to bitterness and cynicism. If they are encouraged to raise delicate issues, however, students must be assured that someone will listen and help if necessary. If informal interaction with peers or faculty cannot give adequate support, students must have access to appropriate psychiatric intervention, at minimal if any cost. Most medical schools employ social workers, psychologists, and psychiatrists in their teaching hospitals and outpatient services, and these experienced therapists could provide students with confidential treatment.

> Seagull offers these seven rules to medical school faculty:
>
> (1) Be kind to medical students. Remember that they are likely to overinterpret what you say. Always give feedback in a positive, constructive manner, so that trust can be built.
>
> (2) Remember that there is a curvilinear relationship between anxiety and learning. Don't overburden the student with anxiety. This pushes him or her to the downward side of the learning curve.
>
> (3) If a student comes to you with a complaint, try to listen carefully and understand the student point of view. Try to see the complaint as a compliment to your fairness. Faculty who are viewed as hopeless bigots or sexists never hear complaints; the students write them off.
>
> (4) Since failure or near-failure is so damaging to medical student self-esteem, try to give constructive help very early if you think a student is heading for academic difficulty.
>
> (5) On those occasions when you are too busy to give time to a student who needs it, you feel that the student needs special help which you are not competent to provide, or you simply don't like a given student, take responsibility for helping the student get to someone else who can give a positive, helping response.
>
> (6) Be sensitive to concerns about sexism and racism. Attempt to change individual, as well as institutional, practices that are offensive to women and minority students.

(7) Let the students teach you. The new medical students are a fascinating group of people. We can learn much from them if we will remember that we do not yet have all the answers.

Teaching medical ethics/teaching interpersonal skills. It has been suggested that formal teaching of medical ethics would sensitize students to moral problems in clinical practice, teach them to analyze and formulate reasonable, ethical solutions, and contribute to the rehumanization of medical education. (Veatch) In addition, questions regarding the doctor's social role, patient and physician responsibility in medical decisionmaking, uncertainty, and emotional distance arise within the context of ethical dilemmas in patient care. Historically, medicine and medical men have been called on to participate in the resolution of important ethical conflicts related to sickness, death, health, and quality of life. And most physicians would agree that the practice of good medicine is synonymous with the practice of ethical medicine.

> Of course the physician must deal compassionately and honestly with the responsibility he or she has in this intimate relationship [with the patient]. But physicians, with few exceptions, have always demonstrated these attributes.
>
> (White)

Based on this assertion that somehow medicine is intrinsically moral, some would deny the need for formal ethics training in medical school. "Medical ethics, as a required course in the medical school curriculum, is simply not necessary, for, by some strange and inexorable process, its very essence is already there." (White) Unfortunately, Dr. White's idealistic conception of health care delivery and the success of medical education in imparting to students humanistic and moral sensitivity as well as scientific and technical expertise is not fully realized. Most graduating medical students are less than optimally prepared to cope with ethical problems in clinical practice.

Veatch and Gaylin propose a scheme for teaching medical ethics in a required lecture course for second-year students given by physicians, ethicists, sociologists, and hospital administrators, followed by informal discussion periods between students and faculty. During the third year (the year of clinical clerkships), students would participate in a dinner discussion series. In this less structured format actual cases can be presented by clinicians and discussed against a background provided by selections from the medical and ethical literature. Also during the third year, in-hospital clinical/ethical case conferences can be held to allow for greater relevance to student's daily experiences on the wards. Finally, intensive workshops on medical ethics would be held for students and faculty as part of elective course work during the fourth year. Veatch and Gaylin implemented their proposals in a program at Columbia College of Physicians and Surgeons, and report very positive responses from both students and faculty.

This type of formal ethics training is of value in that it introduces analytic modes of thought different from statistical medical reasoning, reinforces already present humanistic attitudes, and equips students with effective means of understanding and responding to challenges of medical practice. Moreover, continued close contact with faculty, house officers, and fellow students, in a more informal and less pressured environment than the hospital ward, provides some of that guidance and support called for above.

In contrast with Veatch's and Gaylin's proposal, Siegler suggests teaching medical ethics at the bedside, claiming that:

> Moral discourse in the context of clinical medicine will not become a legitimate enterprise for medical students and house officers until it is used by their clinical mentors at the bedside and until attention to these moral-ethical issues can be shown to improve patient care and physician satisfaction.

He identifies four advantages to teaching ethics at the bedside rather than in the classroom: (1) intensity of the bedside situation ("The physical presence of the patient demands that he be regarded as a subject rather than as an object."), (2) intimate association between technical and ethical competence, (3) participation of the entire health care team, and (4) likelihood of diminishing professional resistance to and suspicion of ethics. He does also recognize the difficulties encountered in attempts to teach ethics on the wards, pointing specifically to unqualified physician-teachers, poor background preparation of students, reluctance on the part of clinical faculty to spend time teaching ethics, and the limitation to issues raised at the bedside and omission of other important issues that apply in other situations.

Nonetheless it is apparent that some attention at the bedside to moral and psychosocial concerns, in addition to exclusively medical-scientific matters, would contribute to more interesting if not more valuable discussions on rounds.

Although these writers propose two very different approaches to teaching medical ethics, they concur that the optimal time for such courses is at the transition from the preclinical to the clinical years, during the latter part of the second year and through the third year of medical school. Perhaps a few introductory lectures in the first year could set the stage for future work, but by and large first-year students are burdened with many adjustments to medical school and have neither the time nor the desire to study medical ethics. Once the student begins to interact with patients (which should be early in the pre-clinical years) and his year of clerkship rotations nears, concerns over matters related to the student-doctor's identity, relationships with patients, decisionmaking in the face of medical uncertainty, and dilemmas of ethical problems in health care become more relevant. It is at this time that formal instruction in ethics could be initiated and then carried through the clinical experience.

However, in laying such extensive plans for revamping medical school curricula, educators should be wary of the pitfalls of hasty and poorly planned programs. Fox warns:

> Perhaps the biggest problem of all, however, has been the inclination of physicians to parachute social scientists into medical schools, expecting them to humanize the education of medical students by their sheer presence and by the few introductory lectures that they are invited to give in the first-year behavioral science course, and to effectively and definitively solve some of the most difficult problems with which the medical profession is faced. These expectations are misguided and inherently unfulfillable. For this reason, I predict that if academic physicians now have the same expectations of moral philosophers, these doctors eventually will experience the same disappointments that they earlier experienced with social scientists.
>
> Although it may not sound spectacular, I strongly believe that the most enduring kind of help that intellectual collaborators from other disciplines can provide is to give you alternative ways of framing these questions and of systematically and probatively inquiring into them. Out of this process should come some new perspectives, if not solutions.
>
> (Fox, *Exclusion from Dialysis*)

There is a need to teach not only medical ethics but also interpersonal skills during the transition to the clinical years. There now exists an extensive literature on the problems in doctor-patient communication (Korsch and Negrete, Francis *et al.*, Davis) and efforts to teach interpersonal skills to medical personnel (Robbins *et al.*, Kahn *et al.*, Fine and Therrien, Engler *et al.*) Without presenting an exhaustive review of that literature much is summed up in this excerpt:

> Medical schools do an admirable job of teaching their students the complexities of medical science, but they still leave the learning of the "art" of medical practice to the individual's own initiative and intuition . . . By clarifying the process we can hope to develop principles that will make it possible to teach something about the

> "art of medicine" in medical school, instead of leaving it solely to intuition.
>
> (Korsch and Negrete)

Several experimental programs designed to teach interview technique and communication skills have been implemented. They vary in format, using role playing among students and between students and faculty, supervised interview sessions with patients, videotaped interviews followed by review and critique. One national survey revealed an already high level of such activities in American medical schools: At least 68% of all medical schools offer a specific course for teaching interpersonal skills, of which 80% were started within the last five years. Despite this evidence of concern, there are still several problems: (1) less than one-third of the courses teach any "specific information-giving/counseling skills"; they are primarily trying to teach listening and information-gathering skills; (2) most courses are taught in the pre-clinical years with "a notable lack of follow-through into the clinical years"; and (3) "only about one-third use any kind of outcome index for evaluation." (Kahn *et al.*)

Interpersonal skill training, like medical ethics training, would be most beneficial in the context of actual patient care. Preliminary, prepatory steps during the second year could serve as a framework for continued development during the third year. Moreover, the fourth year of elective clinical rotations provides an ideal opportunity for more-intensive course work in both of these fields. During the fourth year students have a great deal more time (as they are rarely required to be "on call" nights or weekends), have some, albeit limited, clinical experience, and have begun to define and assimilate their own clinical styles, interview techniques, mechanisms for dealing with uncertainty, and emotional distance. Most are willing, indeed eager, to discuss their own experiences over the past months, and to work towards refining technical and interpersonal competence.

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Minors' Assent or Dissent to Medical Treatment

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Introduction

Although the requirement for the consent of minors involved in medical therapy has been addressed previously, this issue should be reconsidered in light of new knowledge in developmental psychology, the evolution of the theory and practice of obtaining informed consent for intervention with adults, changes in medico-legal statutes concerning minors, and the recognition by society that parents neither own their offspring nor do they always act in their best interest. In this article the current medical/legal status and current views of minors' psychological development in relation to health and disease will be reviewed in order to provide a basis for an ethical analysis of the assent or dissent by minors for medical therapy.

Minors in the Medico-Legal Context

Historically, there has been a wide variability in the age of majority and in the reasons for establishing that age. The age of majority may have reflected the physical development of young men to bear arms or work farmland or of a woman to bear children, but it also seemed to recognize the mental and emotional maturity and personal independence appropriate to an autonomous individual and the assignment of certain responsibilities. At present, in almost all the states, an individual is legally a minor and presumed incompetent until he/she has reached age 18. In this context incompetence denotes the individual's inability to have a full understanding of and appreciation for the impact of decisions and acts made for himself or

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others. In this latter situation, a parent or legal guardian is entitled to make decisions and perform certain acts on behalf of the incompetent.

In the medical/legal context, legislatures and courts have recently expanded minors' rights to give binding consent for reasonable medical intervention without parental consent.[1] First, courts have treated some classes of minors as if they were adults. An "emancipated" minor may, in some jurisdictions, consent to medical treatment. They become emancipated by marriage, judicial decree, military service, consent of the parent(s), or failure by the parents to meet their legal responsibilties. In addition, a minor who is self-supporting and lives apart from his parents is often deemed to be emancipated. The minor in military service is clearly emancipated and, among other things, could consent to medical care because it would be impractical to contact parents for injuries occurring on the battlefield. Motherhood is now also considered evidence of emancipation, regardless of biological age, at least for purposes of consenting to medical treatment for oneself and one's baby or when surrendering the baby for adoption. In many states a teenage mother is emancipated for all purposes.

In addition to liberalization of the concept of emancipation, beginning in the 1950s all states enacted statutes specifically permitting a minor of any age to consent to treatment for venereal disease without parental knowledge. If notification of parents were a precondition of treatment, the teenager would very likely forego therapy rather than have parents find out it was necessary, thus further spreading the epidemic of VD in young people. Most states have also recently developed analogous statutes to include treatment for alcohol and drug abuse. Beyond statutory authority for treatment of these specific conditions, the majority of states provide a specific statutory age (usually 15 or 16, but 14 in at least one state) at which a minor may consent to any medical or surgical care without parental consent.

Even where there is no statute and the minor is not emancipated, however, not a single case has been reported in this country in at least 15 years in which a parent recovered damages from a physician for treating someone age 15 or older without parental consent. If the treatment was appropriate, no claim of malpractice is proven, and the teenage patient was as capable of giving informed consent as an adult; courts have allowed that consent to prevail over parental objections raised after the fact. This trend in case law is known as the "mature minor rule."

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[1] Holder, A.: *Can Teenagers Participate in Research Without Parental Consent?* IRB III:5, 1981.

A teenager, as well as an adult, also has the constitutional right of privacy in some circumstances involving medical care. The Supreme Court has held that parents have no veto over their daughter's decision to have an abortion. The courts have also held that minors do have a right of privacy in obtaining contraception. In contrast, a parent's consent is still necessary for nonurgent treatment of a young child; and the courts have made clear that parents have the right to refuse to allow most elective medical interventions.

From the foregoing, it appears that the law has intuitively begun to modify informed consent standards concerning medical treatment for minors. But, it has been based on a number of different social and medical situations and not necessarily on the basis of the patient's needs, values, or competence. As Annas, Glantz, and Katz[2] have stated:

> It would be most helpful to know at what age a child obtains a true sense of his body and mind, knows what it means to take risks, knows what it means to be harmed or suffer discomfort, knows how to balance risks and benefits, and so forth. If we had this knowledge it might be possible to rationally determine an age at which most people could give an informed consent to medical treatment.

This would allow us to fulfill our ethical obligation for respect for persons as embodied in the two major functions of informed consent—the promotion of autonomy and the protection of the individual's well-being.

Minors' Involvement in Informed Consent

To determine whether or not minors can participate in the informed consent process, we need to identify those psychological capacities that develop in an individual to render him/her competent for this activity. Their major characteristics should be ones that you would expect most adults to demonstrate most of the time. This task is complex since we need to examine systematically which minors are capable of assuming what decisionmaking roles in treatment situations with what consequences for the minor, the family unit, the professional, and society. Our own attempts to respond in an ethical and therapeutic way to minors in treatment require such information, lest in our zeal we unreflectively burden some minors with decisions they cannot make intelligently and bear responsibilities for action (sometimes to their detriment) or deny to some the opportunity to make decisions of which they are sufficiently capable.

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[2] Annas, G., Glantz, L., Katz, B.: LAW OF INFORMED CONSENT IN HUMAN EXPERIMENTATION: CHILDREN. Appendix to the report and recommendations concerning research involving children. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. DHEW Publication No. (OS) 77-0005.

Before proceeding with the several factors involved in the development of competence it would be helpful to identify characteristics that are more often found in minors and that may affect their decisonmaking ability as well as that appear to raise questions concerning the individual's rationality. First, a minor's values are more likely to change with time than those of an older individual. His life goals are not well established and adults are likely to somewhat discount his dissent or assent because of the expected changeability of these values and goals. Second, because of a lack of personal experience or development the minor is less likely to recognize and take into account the possibility of a change in his values over time and is thus less reflective about his choices. It is only in adolescence that a sense of identity develops (that is, a perception of what one might become or want in the future), so that any future consequences of current actions take on a different meaning than they previously might have. In addition, because of their newfound awareness of bodily appearance, teenagers are particularly concerned with any treatments that will affect it in an adverse manner. It should be emphasized that these characteristics of "immaturity" are found in older individuals as well, but less frequently and less strikingly. Although they may modify a minor's decisions, they are not in themselves sufficient indication of a lack of competence to consent.

There are several different levels of involvement of minors in informal consent. First, some have argued that certain broad classes of minors or minors with certain medical conditions should be allowed by law to consent to treatment independent of their parents' consent or knowledge (as in the case of abortion or the treatment of VD). It must be realized, however, that if parents can be held responsible for their minor's financial debts, they may come to know about the condition and this may affect minors' decisions about thier medical treatment.

The second type of consent has both legal and ethical connotations. Should minors be provided by law, or be provided by ethical principle, the power to nullify parental consent? There is a third sense to the involvement of minors in the consent process. This is primarily the individual's need to know or participate when treatment is being decided, but not in the sense of a contract or veto power. Here the issue of a minor's competence is not as critical as in the other two, since what is proposed for the professional is an ethical responsibility rather than a legal obligation to justify overriding a child's consent or dissent.

Competence to Provide Independent Consent. To determine whether or not broad classes of children can be viewed as competent to provide independent consent, we must examine the development of the elements of informed consent. These are understanding, rationality, and voluntariness.

Understanding. In the context of consent situations, understanding is the match between the information given to the patient and the patient's own paraphrase of that of which he/she has been informed.[3] The adequacy of the match depends in part, of course, on the way the information is communicated and needs to be appropriate to each individual. But certain capacities of the patient—for example, general intellectual capacity, the patient's familiarity with the content area, and the patient's linguistic background—are expected to influence a match as well. Furthermore, some disorders and treatments are simpler to conceptualize than others[4] and, therefore, easier to describe than others.

Psychological studies of normal children show that their conception of illness—their understanding of its cause and cure—is closely related to the sequence of cognitive developmental levels[5] as described by Piaget[6] and by Warner.[7] According to Piaget, the first level, prelogical thinking, is typical of children between two and six years of age. It is characterized by children's inability to distance themselves from their environment and results in explanations accounting for the cause-effect relationship in terms of the immediate spatial and/or temporal cues that dominate their experience. In both types of prelogical explanation of illness—phenomenonism and contagion—we see children being overly swayed by the immediacy of some aspects of their perceptual experience. Phenomenonism represents the most developmentally immature explanation of illness. The cause of the illness is an external concrete phenomenon that may occur with the illness but that is spatially and/or temporally remote. Children at this stage are unable to explain the manner in which these events cause the illness. Bibace and Walsh[8] give the following example of this stage of conceptualization:

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[3] Grisso, T., and Vierling, L.: *Minors Consent to Treatment: A Developmental Perspective.* PROFESSIONAL PSYCHOLOGY. 412-426, August 1978.

[4] Neuhauser, C., Amsterdam, B., Heinz, P., Steward, N.: *Children's Concept of Healing, Cognitive Development and Locus of Control Factors.* AMERICAN J. ORTHOPSYCHIATRY 48:335-341, 1978.

[5] Bibace, R., and Walsh, M.: *Development of Children's Concept of Illness.* PEDIATRICS 66:912-917, 1980.

[6] Piaget, J.: THE ORIGINS OF INTELLIGENCE IN CHILDREN. New York International University's Press, 1952.

[7] Warner, H.: COMPARATIVE PSYCHOLOGY OF MENTAL DEVELOPMENT, New York Science Editions, 1948.

[8] Bibace, R., and Walsh, M.: *Children's Conception of Illness,* in NEW DIRECTIONS FOR CHILD DEVELOPMENT: CHILDREN'S CONCEPTION OF HEALTH, ILLNESS, AND BODILY FUNCTION. Edited by Bibace, R., and Walsh, M., Jossey-Bass, San Francisco, 1981.

> "How do people get colds?"—"From the sun."
> "How does the sun give you a cold?"
> "It just does, that's all."

Contagion is the most common explanation of illness offered by the more mature children in the prelogical stage. The link between the cause and the illness is accounted for only in terms of mere proximity or magic. Thus, a kindergarten or second-grade child defines illness only when he is told or is given external signs of his illness, such as, "You have to stay in bed." He believes he gets sick because of a concrete action he does or fails to do, thinks he might keep from getting sick by obeying a set of rigid rules associated with illness, and expects to recover from illness either simply automatically or by rigidly adhering to another set of rules such as staying in bed and drinking chicken soup.

Concrete-logical reasoning is manifested by children roughly between seven to ten years of age. In this stage the major developmental shift is in the accentuation of the differentiation between self and others. Contamination characterizes the explanation of younger children in this stage. The cause is perceived as a person, object, or action external to the child that has an aspect or quality that is bad or harmful for the body. Such a cause brings on illness through the child's body physically contacting the person or object (e.g., through touching, rubbing), or through the child's physically engaging in a harmful action and thus becoming contaminated. An example of this, excerpted from Bibace and Walsh,[9] follows

> "What is a cold?"
> "It's like in the wintertime."
> "How do people get them?"
> "You're outside without a hat and you start sneezing. Your head would get cold, the cold would touch it, and then it would go all over your body."

Internalization is a type of illness explanation typically offered by older children in the concrete-logical stage. The external cause, usually a person or object, is linked to the external effect of illness through a process of internalization—for example, swallowing or inhaling. Many children of this age believe an illness to be caused by germs whose very presence is sufficient to make the child sick.

According to Piaget, children who are approximately 11 years of age or older manifest formal-logical thinking. At this stage, there is the greatest amount of differentiation between the self and the other. There is now an understanding that there are multiple causes of illness, that the body may respond variably to any combination of agents, and that host factors within the body interact with the agent to cause or cure the illness. Again, there are two forms of explanation within this stage. Physiological explanations are usually preferred by the younger children in this stage. Although the cause may be triggered by external events, they believe the source and nature of the illness lie in specific internal structures and functions. The cause is usually described as the nonfunctioning or malfunctioning of an intersenal organ or process, explained as a step-by-step internal sequence of events culminating in that illness.

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[9] *Ibid.*

Psychophysiological explanations express the most mature understanding of illness. As in physiological explanations, the illness is described in terms of internal physiological processes, but the child now perceives an additional or alternative cause of illness—a psychological one. The person is aware that a person's thoughts or feelings can affect the way the body functions. This sequence of development of understanding about illness parallels conceptual development in other content areas, such as physical causality (e.g., what causes rain or wind) although it seems to lag a bit.[10]

Initial studies in the medical setting revealed that in comparison with their healthy counterparts, younger ill children give less mature, objective, well-articulated explanations of illness.[11] Hospitalized children often ascribe the cause of their illness to disobedience of parental commands and may interpret their hospitalization as rejection or punishment.[12] Younger children also perceive medical treatment as a form of punishment for being bad.[13] Older minors with chronic illnesss, however, understand illness better than healthy children of the same age.[14] This is probably due to the actual experiencing of illness and hospitalization rather than to a basic difference in cognitive function between healthy and sick children.

Reasoning. Giving consent rationally requires several cognitive capacities. These include abstract reasoning, inductive and deductive logical processes, and cognitive complexity, and they correspond with the capacities that Piaget has associated with the emergence of the formal operations stage of cognitive human development. First appearing at about age ten, this stage includes the development of increased cognitive capacity to bring certain operations to bear on abstract concepts in problem solving situations.[15] For example, although a child at the previous concrete operational stage can think logically, it is questionable whether prior to the formal operations stage he or she can perform inductive and deductive operations or hypothetical reasoning at a level of verbal abstraction that would be needed in many consent situations involving treatment alternatives and risks. What is particularly pertinent to the informed consent process is that with the development of the formal operation stage the child is now capable of differentiating between the self and the environment and of understanding that the sources of illness are located within the body, even though the external agent is often described as the ultimate cause.

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[10] Perrin, E., and Gerrity, S.: *There is a Demon in Your Belly: Children's Understanding of Illness.* PEDIATRICS 67:841-849, 1981.

[11] Cook, S.: *The Development of Causal Thinking with Regard to Physical Illness Among French Children*, Thesis, University of Kansas, Kansas City, 1975.

[12] Brodie, B.: *Views of Healthy Children Toward Illness.* AM. J. PUBLIC HEALTH 64:1156-1159, 1974.

[13] Brewster, A.: *Chronically Ill Hospitalized Children's Concepts of Their Illness.* PEDIATRICS 19:355-362, 1982.

[14] Perrin, E.: Personal Communication.

Further, emergence of the formal operations stage allows a child to become sufficiently flexible in thinking to attend to more than one area of a problem at once—for example, to entertain alternative treatments and risks simultaneously. The sequence in which these categories are ordered empirically is important, not only in terms of cognitive development, but in defining the kind and extent of personal control exerted by the person over what he or she believes to be the cause of the illness. There is now good evidence that by age 14, a substantial percentage of minors have attained the cognitive development stage of formal operations that is associated with the psychological elements of rational consent.[16] There is, however, a wide variability in the age of attainment of the formal operation reasoning, indicating that we cannot equate this cognitive stage with a definite age period.

It should be mentioned that not all adult subjects attain the formal operational level. Therefore, it may not be warranted to consider formal operational reasoning as the sole standard for participation in informed consent. Further, it has been argued that "practical reasoning" involves such elements as judgment, self-knowledge, and character, which require a long period of moral apprenticeship or paternalistic intervention in the child's decisionmaking. As commendable as these attributes may appear, they are so unpredictable in their attainment and so changeable in a person's life that their use as a criterion for involvement in informed consent is questionable.

In relation to specific clinical situations, a recent study by Whitehorn[17] attempted to address empirically the question of minors' competence to consent. Minors aged 9 and 14 were compared with subjects aged 18 and 21 to test for developmental differences. A measure of competency to render informed decisions was developed to assess "competency" according to four standards: (1) capacity to express a treatment preference, (2) capacity to reach a "reasonable" or "responsible" decision, (3) capacity to reason "rationally" and "logically," and (4) capacity to demonstrate "understanding" of the relevant information regarding treatment alternatives. Four hypothetical medical and psychological treatment dilemmas were used for testing. The findings of the study were consistent with the cognitive developmental theory previously mentioned and suggest that 9 year olds are less competent than adults or 14 year olds with respect to their ability to reason "logically" and to "understand" the treatment information provided. These results indicate that adolescents 14 years of age or older may be developmentally competent to render autonomous treatment decisions. This experiment, however, was performed on healthy individuals and therefore is not exactly the same as in many medical settings with sick or hospitalized individuals, in whom it has been suggested that there is a regression in cognitive development during illness.

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[15] Grisso and Vierling, *op. cit.*

[16] *Ibid.*

[17] Whitehorn, L: *Competence to Render Informed Treatment Decisions: A Comparison of Certain Minors and Adults*, Thesis, University of Pittsburgh, Pittsburgh, PA, 1980.

What, then, can be concluded about the first two elements of informed consent? Based on this review of developmental psychology of well and ill minors, a child's inability to conceptualize disease and to reason about it prior to the formal operational state means that usually children less than 10 years old are not competent. Thus, any consent that is obtained based on an advanced (physiologic or psychophysiologic) explanation to minors who are at the preconventional or concrete operational conceptual levels cannot be considered what might be called "valid" consent.[18] Although a minor of these ages understands that he is being asked for consent, he lacks the ability to freely understand and appreciate the information given.

Further investigations are needed to determine whether explanations can be provided to children who are at preconventional or concrete operational conceptual levels that will enhance their understanding and will be scientifically accurate. From the standpoint of understanding and reasoning, minors aged 11 to 14 appear to be in a transition period in the development of important cognitive abilities, but there may be circumstances that would justify the sanction of independent consent by these minors for limited purposes when competence can be demonstrated in individual cases. On the other hand, there appears to be no psychological grounds for maintaining the general assumption that minors 15 years or older cannot provide competent consent.

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[18] Gert, B. and Culver, C.: COMPETENCE TO CONSENT: A PHILOSOPHIC OVERVIEW IN PHILOSOPHIC PROBLEMS IN MEDICINE AND PSYCHIATRY. Oxford University Press, in press.

Voluntariness. Registering one's assent or dissent in treatment situations is a social act. Individuals differ widely in their general tendencies towards conformity to social expectations and requests by authority. Thus, it is meaningful to speak of a person's competence to provide *voluntary* consent to treatment—that is, to provide consent that is not merely an acquiescent or deferential response to authority. Studies[19] have shown a negative relationship between age and conformity, and that minors before the age of 14 or 15 are unlikely to assert themselves well against "authority figures," such as physicians or parents. Minors 14 years or older are more likely to believe they are in control of their health and illness outcomes. In addition, as children's illnesses worsen, the strength of their own control of the situation lessens.[20] Therefore, it would appear unlikely that a minor under 14 years of age, particularly one who is ill, will dissent in the presence of parents who have already agreed to a proposed treatment. It has also been found that there are significant social class differences that may modify children's willingness to express their preference.[21]

From the foregoing, it would appear that in considering adolescents under the age of 14 or 15 it is much more appropriate to use the term "assent" to the recommended treatment rather than voluntariness. From a procedural standpoint, a determination of the actual wishes of the child may be better made in a separate interview with a professional, such as a social worker or psychologist, who does not directly represent the interest of the parents or the physician.

Some sick children may refuse to become involved in the consent process. This refusal may be due either to a need to deny the worsening of the child's illness by not hearing the discussion, or to an autonomous wish to relinquish his/her decisonmaking role to others, or to an acquiescence to the authority of family and/or the physician. Under these circumstances, insisting on the minor's presence may be considered a paternalistic action requiring justification based on patient benefit.

Even some well children may express a need for their parents to assist in decisionmaking when it comes to health-related problems. A group of school children aged six to nine were presented with the opportunity to participate in an experimental trial of swine influenza vaccine that required them to receive an injection of the vaccine and two venipunctures.[22] If they felt the decision to participate was one they were unprepared to make by themselves, the parents would be contacted to share their decisionmaking with them. One-third of the children felt unable to make a decision by themselves. On the other hand, researchers requesting seventh-grade children (ages 11 to 13) to volunteer for topical fluoride treatments or to use a fluoridated mouth rinse at home obtained a parent-free participation rate of between 95 and 100%.[23] Although age differences between this and the vaccine study may have affected the volunteer rate, it is also possible that differences in the nature of the harm and risk of harm the children were requested to accept as well as differences in the benefit that the children could be promised influenced the children's ability to assent without parental guidance. Pertinent to this aspect of the discussion is that psychologists have found that even by the eighth grade (14 years old) very few children understand prevention of illness in any more abstract terms than those typical of fourth or sixth graders.[24] Thus, even young teenagers might request parental assistance in deciding whether to participate.

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[19] Grisso and Vierling, *op.cit.*

[20] Perrin, E.: Personal Communication.

[21] Melton, G.: *Children's Concepts of Their Rights.* JOURNAL OF CLINICAL CHILD PSYCHOLOGY 9:186-190, 1980.

[22] Lewis, C., Lewis, M., Ifeckwunigue, N.: *Informed Consent by Children and Participation in an Influenza Vaccine Trial.* AM. J. OF PUBLIC HEALTH 68:1079-1082, 1978.

Ability to Nullify Parent's Consent. When minors under 14 years of age dissent from treatment, it has been suggested that they are either unusally hostile or terrified. In medical therapeutic situations, it would appear that it would be appropriate to try to determine the reason(s) for this dissension to discover whether or not these reason(s) can be eliminated. For example, Koocher[25] describes an extremely hostile 15 year old with an amputation for a bone tumor who, it was learned by psychological intervention, believed that because her parents quarreled especially around the time of her treatment, her illness would cause her parents to divorce. By encouraging open discussions between her and her parents, tensions were released and the patient became more cooperative.

But, what if the minor continues to dissent? In this situation, the minor is refusing assent based on his or her own values, despite the possibility of future physical benefit or because of inchoate nonconformity. If, however, there is evidence of sufficient knowledge and intelligent understanding of the illness and its treatment by the minor, his or her decision should be taken seriously and the dissent is less likely to be overridden, especially when the child has had more experience and is better educated about the illness and its consequences. In some cases differences between the parties can be resolved. If they cannot, however, the courts should be involved for the protection of all parties concerned.

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[23] Kegeles, S., and Lund, A.: *Informed Consent of Children in Field Trials.* AMERICAN DAY PUBLIC HEALTH 69:722-723, 1979.

[24] Perrin and Gerrity, *op. cit.*

[25] Koocher, G.: *Consultations with Pediatric Cancer Patients*, in PSYCHOLOGICAL ASPECTS OF CHILDHOOD CANCER, edited by Kellerman, J., Charles C. Thomas, Springfield, IL, 1979.

Participation in Decisonmaking Process. The third way minors are involved in consent concerns the obligation to inform minors and to include them when treatment is being decided. Here the issue of the minor's competence in the legal sense is not as critical as in the former cases since the purposes of this type of involvement are ethical, humanistic, and therapeutic. Health care providers have a responsibility to treat minors with respect by dealing with them honestly and openly. Thus, their paramount goal should be that eventually the minor gets all the information that is provided to the parents (or more, if wanted). Even, however, when the minor is not the major decisionmaker, accommodations for his or her needs and values should be recognized and integrated in decisionmaking.

The physician-child patient relationship is critical to the participation of the minor in informed consent. When the child is attended by a parent the physician usually directs matters concerning the child's illness to the parent at the parent's level of conceptualization. This does not satisfy the child's needs to know about the illness nor does it encourage a sense of personal control by the patient. Recognition, by the physician, of the patient as the individual with the problem may improve this situation.

In this regard, in discussions with minors it would be important to determine how they view their illness in terms of what caused the illness, how it has changed bodily functions, and what personal significance it has to that individual. Recognition and correction of misconceptions by the health professional may help patient care. For instance, since young children frequently view illness as a form of punishment, an attempt should be made to detect and correct, when possible, any fears of self-blame, thus permitting a reduction in anxiety. Helping children to feel that their ideas about themselves and their illness are understood and are not weird contributes to a workable, rewarding health-professional/patient relationship. For example, many 5- or 6-year olds on hospital pediatric units become inexplicably upset and ask to be moved to another room because of their preoccupation with catching the disease from their roommate. In this instance, even if the child's physical location cannot be changed, the health professional can at least accept rather than dismiss the patient's fear by offering genuine reassurance and explaining the situation. In addition, by directing explanations of illness and treatment to the specific cognitive development level of the child there will be much more likelihood of adequate conceptualization.

It should also be emphasized that children are interested in their health as a means of performing desired activities, such as playing with friends, attending school, and participating in sports.[26] Some treatments produce significant side effects and it is very difficult for minors to understand why they are going to be made to feel sick when they may just then feel relatively well. To establish and maintain a trusting relationship, it is important to discuss openly the possible harms and benefits of treatment or prophylaxis within the framework of the child's needs and values. This will require determining not only the child's understanding of disease causation and effect on bodily function but also how the disease and treatment may interfere with his or her needs and values. Appropriate discussion and response to these issues and concerns will prepare the minor for subsequent untoward effects, reduce stress in the child, and, it is to be hoped, facilitate compliance.

Thus special strategies of interview and explanation are needed to assist the child's understanding and control of illness based on the cognitive developmental level of the child. Although there has been some attempt to explain illness and its management in language and concepts appropriate to a child's level of development, much needs to be done to improve the communication skills of the pediatric health professional.

As a manifestation of the respect that we wish to show minors, we also need to recognize their sensitivity for privacy and confidentiality. It is, therefore, important to emphasize that the older minor, for purposes of privacy and confidentiality, should have his or her own time with the health care professional to be allowed to express any concerns and to be consulted about how much of his or her problems or illness should be shared with others. Such an approach would allow minors to seek help for problems they might not mention without a guarantee of privacy.

The Very Sick Minor

Some clinicians state that all very sick minors should initially be told their diagnosis and prognosis when treatment is discussed. It has also been reiterated that children generally learn quickly something about the nature of their illness and whether or not it is potentially fatal. For instance, Bluebond-Langner reports[27] that children were each other's chief source of information on a leukemia ward; information was exchanged in the bathroom about things adults weren't even aware the children knew about, such as which children were dying and what the dying process was like. Not telling the truth about the diagnosis and/or its seriousness immediately demonstrates a lack of respect of minors as well as threatening the trusting relationship that physicians and/or parents wish to establish and hold. Yet some caveats are required.

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[26] Natapoff, J.: *Children's View of Health: Adult Developmental Studies.* AM. J. PUBLIC HEALTH 68:995-1000, 1978.

[27] Bluebond-Langner, M.: THE PRIVATE WORLD OF DYING CHILDREN. Princeton University Press, Princeton, NJ, 1978.

Explanation of illness and its management requires language and concepts appropriate to the child's level of conceptual understanding. There is some evidence to suggest that hospitalized children demonstrate less advanced notions of illness causality than healthy children. Determinants of such a difference have not been explored, but may include cognitive regression due to the stress and anxiety associated with acute illness and/or hospitalization. Nonhospitalized children with a chronic disease have not been systematically studied. Lowered cognitive functioning during hospitalization, whatever its determinants, would suggest that when explanations are to be made, they should be scaled down to the minor's level of cognitive sophistication. Studies have also shown that a child's state of cognitive development had an effect on the amount of control he felt he had over the healing process. Concrete operational children felt that they had more control over healing than did the preoperational children. This difference may reflect the fact that, realistically, older children are able to do more for themselves than children 4 to 5 years younger and the older child responds to treatment that will allow him a measure of control over his own healing process.

Further, when it comes to providing a fatal prognosis, it should be remembered that increasing levels of cognitive development are linked with increased levels of abstraction about death in children and that advanced levels of cognitive development are related to increased use of reality-based appraisal in conceptualizing death.[28] It is generally agreed that by age 14 or 15 most adolescents can understand the meaning of death as well as adults do. It is important that care providers understand that younger minors may not understand imminent death on the same basis as older individuals, although they certainly may sense that something is very seriously wrong. Prior to acquisition of concrete operational thought, magical or egocentric thinking creates a potential hazard since misrepresentations related to reversibility of death notions are possible. It is also important to bear in mind which phase of the illness the child is in. Within days or weeks of death, children who are actually dying do become aware before they can conceptualize it that they are truly dying. With such children, an honesty about death is called for. However, a growing number of children with some illnesses, such as cancer, cystic fibrosis, or renal disease, are no longer dying—they are living for an increasingly longer period, even those who will eventually die. The circumstances, therefore, are different for those children, especially those under 10 who are in the early stages of a disease or are in remission. Although their understanding of the meaning of the term "death" depends upon their developmental level, death encounter plays a very important role. Under these circusmtances a hope is called for that does not deny the implication of the disease but that can bolster a positive attitude in the child's will to live and fight the disease.

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[28] Koocher, G.: *Children's Conception of Death* in NEW DIRECTIONS FOR CHILD DEVELOPMENT: CHILDREN'S CONCEPTION OF HEALTH, ILLNESS, AND BODILY FUNCTION, edited by Bibace, R., and Walsh, M., Jossey-Bass, San Francisco, 1981.

A second important concern in the presentation of the diagnosis, treatment, and prognosis with very sick minors is that sufficient emotional coping supports be in place, particularly when the prognosis is in doubt or the child is in the terminal stages of illness. It must be realized that the concerns of young children concerning impending death are not the same as those of adults. Children view death as a punishment for wrongdoing or express fear of separation. The minors' caretakers must attempt to address these emotional needs rather than trying to address the concept of death from a more advanced perspective.

Emotional supports are principally derived from the parents and other family members. For those families who can share the traumatic experience with each other and support the patient, discussing the poor outcome with the minor is the desirable approach. If, as mentioned previously, a long-term remission or eventual recovery is expected, there is no urgency for disclosure of a potential fatal outcome in the patient who does not request specific information. Under these circumstances there does not appear to be good justification for physicians or nurses overriding the parents' wish not to divulge the information. At times, the patient, in order to protect his or her parents or to maintain denial, may not ask any direct questions and may cope by participating in "mutual pretence," as Bluebond-Langner describes it. During the period of nondisclosure, counseling should be offered to the parents to assist them in coping with the serious prognosis so that if the patient's illness enters a terminal state the parents can be involved in presenting an honest and open approach about death.

On the other hand, we must be sensitive and respond to those patients and those times when more information is wanted. One approach to patients is through their surface concerns.[29] By providing educative information and assurances in a direct and open response to the patient's concerns, a maximum amount of support can be provided without imposing unsolicited and potentially anxiety-provoking data on the child. This also will establish a climate within which the child will be able to raise more threatening fears as they come to mind. It is important to reiterate that the processes of disease understanding and explanation remain developmental and age-related. Despite the fact that younger children may use the term "death" and may do so relatively frequently, their understanding of the term is not the same as that of an older individual. It is, therefore, critical in the treatment of very sick children that health care providers ask questions that pinpoint the children's age-dependent level of understanding of what will happen to them. With these caveats in mind, when children ask questions about the seriousness of their illness and possible fatality, particularly during the terminal stage, overriding a parent's wish for nondisclosure appears justified if adequate support can be provided.

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[29] Koocher: *Consultations with Pediatric Cancer Patients, op. cit.*

The Role of Parents in Minors' Consent

Parents represent the interests of the family as an integrated whole in addition to representing their own interest. We should not interfere with their authority so long as that authority is not abused. By soliciting the parents' permission for informed consent we are respecting that authority. As participants in their children's health care, however, parents can play a critical role in the consent process with minors of limited competence. First, parents are most knowledgeable about the minor's ability to conceptualize and to reason about health-related matters and other concerns and can tell health care professionals about this ability. Second, they can provide important assistance interpreting information and concepts to their child about these matters. Third, and most important, the parents are critical in establishing a climate in which health professionals are seen by the minor as allies of the parents for the child's welfare in health and disease.

As discussed, it is clear that competency to consent requires a number of different attributes and develops in children over a period of time. It can, however, be accelerated by such things as education, training, and experience. Most important, it has been shown that an inverse relationship exists between potential health behavior and perception of vulnerability to health problems among people with a high degree of perceived internal control. There is also an inverse relationship between perceived internal control and perception of vulnerability to health problems in persons for whom good health is salient.[30] These correlates indicate that efforts to heighten a person's perceived internal control and concern for health could lead to positive health behavior in adults by encouraging perceived internal control when they are younger. In order to increase the minor's perception of internal control it would, therefore, also appear to be the obligation of parents and health providers to establish a climate that will encourage the development of the capabilities required for competency to consent, and then to grant autonomy to each minor individual with the attainment of those capabilities.

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[30] Cochman, D.: *Some Correlates of Children's Health Beliefs and Potential Health Behavior.* J. HEALTH SOC. BEHAVIOR 12:148, 1971.

On the other hand, during the period of the minor's dependency and vulnerability there can be flagrant abuse of the consent process through deception, undue inducement, or coercion of the minor by either parents or health care providers. Thus it is the responsibility of one or the other or of society to intervene on the minor's behalf as it relates to the consent process if such instances occur. In this fashion a set of checks and balances are provided for the benefit of minors, parents, and health care providers.

Conclusion

In summary, it is important to communicate with minors about their diagnosis, treatment, and prognosis of illness in terms that can be tolerated, understood, and utilized. On the other hand, the psychological competencies they may lack or possess are important determinants of their decisionmaking ability and of their ability to conceptualize about illness and to express their wishes for themselves. This should be borne in mind in relation to the informed consent process in pediatric medicine. The wide variations in competence among individual children make it important that a determination be made concerning the level of understanding and reasoning ability that each individual has about his or her illness. Communication at that level will best enhance the minor's participation in decisionmaking and the informed consent process. The developmental psychological approach suggested here would, thus, provide autonomy to those individuals capable of assuming it without denying protection to those who are incapable of assuming autonomy.

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On the other hand, during the period of the minors' dependency and transition there can be flagrant abuses of the consent process through deception, undue influence, or coercion of the minor by either parents or health care providers. Thus it is the responsibility of one or the other or of society to intervene on the minor's behalf as it relates to the consent process if such instances occur. In this fashion a set of checks and balances are provided for the benefit of minors, parents, and health care providers.

Conclusion

[illegible] minors, relative to the informed consent process, in pediatric medicine. The wide variations in competence among individuals [illegible] suggest [illegible] the level of understanding and reasoning ability [illegible] decision-making and the informed consent process [illegible]. The operational and ethical approach suggested here would, thus, provide [illegible]

The Law of Informed Consent

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Despite the fact that the phrase "informed consent" did not enter the legal lexicon until 1957,[1] its antecedents have been expressly recognized in the context of medical treatment since the beginning of this century[2] and more generally for hundreds of years in the English common law.[3] At this time, the doctrine of informed consent has been affirmatively recognized in case law or statute in all but three American jurisdictions[4] and only one explicitly purports to reject it.[5]

The legal doctrine of informed consent imposes on physicians[6] two general duties: to disclose information about treatment to patients and to obtain their consent before proceeding with treatment.

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[1] See Salgo v. Leland Stanford Jr. University Board of Trustees, 154 Cal. App.2d 560, 317 P.2d 170 (1957).

[2] See, e.g., Schloendorff v. Soc'y of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914); Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918).

[3] Nonconsensual medical treatment involves either a harmful or offensive touching of the person and has therefore long been remediable, at least in theory, under the writ of trespass. See generally, 1 F. Harper & F. James, The Law of Torts, Little, Brown, & Co., Boston (1956) § 3.1-3.3, at 211-20.

[4] Neither the appellate-level courts nor the legislatures of Connecticut, South Carolina, or West Virginia have considered the informed consent doctrine.

[5] Georgia purports to reject the informed consent doctrine, see Young v. Yarn, 136 Ga. App. 737, 222 S.E.2d 113 (1975), though its statute does require that patients be told "in general terms the treatment or course of treatment. . . ." Ga. Code § 88-2906.

[6] The term "physician" is used here to include all health care practitioners to whom these two duties apply. In some states, the specific types of health care professionals who must obtain informed consent are specified in a statute. See Alan Meisel and Lisa D. Kabnick, *Informed Consent to Medical Treatment*, 41 U. Pitt. L. Rev. 407, 410-13 n.12 (1980). In general it is safe to say that independent practi-

Physicians' Duties

Information. The physician's duty to disclose information about treatment is what distinguishes the informed consent doctrine from the earlier requirement of consent to treatment, in which a physician satisfied his or her obligation to patients if patients merely understood in a general way the nature of medical procedures that would take place. By contrast, the informed consent doctrine requires that patients be provided with a greater quantity of information to enable them to make intelligent choices about treatment.

Standard of disclosure. The adequacy of a physician's disclosure is measured by what is referred to as a "standard of care."[7] This is a legal yardstick or word-formula by which, in a particular case, the factfinder (*i.e.*, the jury or, if none, the judge) determines whether the information that the physician gave the patient prior to treatment complies with or deviates from what the law requires. In informed consent cases the standard of care is referred to as the standard of disclosure.

There are several variations on this general standard. In some jurisdictions, whether or not a physician has provided the necessary information to the patient is determined by reference to the custom among physicians in general. Specifically, whether a particular physician's disclosure is legally adequate depends on whether it is what a reasonably prudent physician would have disclosed to a patient in the same or similar circumstances.[8] This is referred to variously as a professional or customary standard. In other jurisdictions the adequacy of dis-

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tioners such as chiropracters, dentists, allopathic and osteopathic physicians, podiatrists, and psychologists must obtain informed consent. In those jurisdictions in which nurse-practitioners and physicians' assistants are permitted to perform procedures generally recognized as the practice of medicine, they too should obtain informed consent from their patients.

[7] The most familiar standard is that of "due care" that applies in negligence cases, namely the care of a reasonably prudent person under the circumstances.

[8] Many jurisdictions traditionally have applied a "locality" rule in medical malpractice litigation in establishing the standard of care, namely that a physician is held to the standard of a reasonably prudent practitioner in the same or similar locality. *See, e.g.*, Small v. Howard, 128 Mass. 131, 136 (1880), *overruled*, Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968). Although the locality rule is on the decline, *see* Jon R. Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DePaul L. Rev. 408 (1969), it is not entirely defunct. Those jurisdictions that have not yet abandoned it generally apply it in informed consent cases as well. In addition, a number of informed consent statutes expressly adopt a locality rule in informed consent litigation. See Del. Code Ann. tit. 18, § 6852(a)(2) (Cum. Supp. 1978); Fla. Stat. Ann. § 768.46(3)(a)(1) (West Cum. Supp. 1979); Idaho Code § 39.4304 (1977); Ky. Rev. Stat. Ann. § 304.40-320(1) (Baldwin Cum. Supp. 1979); N.C. Gen. Stat. § 90.21.13(a)(1) (Cum. Supp. 1979).

closure is judged by reference to what a reasonable person in the patient's situation would have found material to making a decision about the treatment in question. Under this rule, the formulation of the standard of disclosure is taken away from expert medical witnesses and given to the jury. This is referred to variously as a lay, legal, reasonable person, or patient-oriented standard. Finally, the adequacy of disclosure could be measured by reference to what the particular patient would have deemed material to making a decision about treatment, rather than by what the medical profession or a jury thought should have been material.[9] Some jurisdictions, although embracing the informed consent doctrine, fail to adopt any standard of disclosure. The preeminent example is Texas, which by statute and regulations prescribes what risk-information is to be disclosed for which procedures.

Elements of disclosure. The standard of disclosure marks out the broad boundaries of what physicians must tell patients. To assist in fulfilling this obligation, courts and legislatures have enumerated certain kinds of information about medical procedures that must be given to patients—what is referred to as the "elements" of disclosure. The disclosure of the hazards of treatment—often referred to as risks, or sometimes side effects—is at the heart of the legal requirement, although this centrality has been severely criticized by scholars. Precisely which risks must be disclosed is determined differently in different jurisdictions. Some statutes are very specific and require that only certain risks, such as those of "brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars," be disclosed.[10] More commonly, physicians are required to disclosure those risks that are "material,"[11] "substantial,"[12] "probable,"[13] or "significant."[14] To aid physicians further, courts and legislatures sometimes specify that certain risks need not be disclosed. These seem to fall into two groups—those that probably would not concern pa-

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In those jurisdictions that do not expressly adopt a locality rule, the phrase "same or similar circumstances," which forms a part of the description of the standard of disclosure, may form the basis for the imposition of a locality rule. See 1 David Louisell and Harold Williams, Medical Malpractice, New York, Matthew Bender & Co. (1977) § 8.04, at 200-01.

[9] Only one jurisdiction has even come close to adopting this standard of disclosure, and it is not even clear that it has. See Scott v. Bradford, 606 P.2d 554, 558 (Okla. 1980).

[10] See, e.g., Iowa Code Ann. § 147.137 (West Cum. Supp. 1979); La. Rev. Stat. Ann. § 40:1299.40 (West Cum. Supp. 1980); Ohio Rev. Code Ann. § 2317.54 (Page Supp. 1978). These statutes are derived from the American Medical Association's model "Consent to Treatment" law, 236 J.A.M.A. 1011 (1976).

[11] See, e.g., Poulin v. Zartman, 542 P.2d 251, 275 n.57 (Alaska 1975).

[12] See, e.g., Fla. Stat. Ann. § 768.47(3)(a)(2) (West Cum. Supp. 1979).

[13] Haw. Rev. Stat. § 671-3(b) (1976).

[14] See, e.g., Utah Code Ann. 78014-5(1)(d) (1977).

tients because they are "remote"[15] or "minor,"[16] and those that patients do not need to be told about because they are "common,"[17] "known,"[18] or "usual."[19]

In addition to the disclosure of the risks of treatment, physicians are also ordinarily required to inform patients of the "nature" of the procedure, the anticipated "benefits" of the procedure, and any "alternative" procedures. Some jurisdictions also require patients to be informed of the "purpose" of the procedure.[20]

Causation. It is uniformly held that a physician's failure to provide a patient with adequate information is not a legal wrong to the patient in itself.[21] Rather, in order for there to be a legal wrong, the risk that the physician failed to disclose or to explain adequately must actually befall the patient, or must "materialize" as the courts say. This is referred to as the "materialized risk" requirement.[22] Closely related to the requirement that the patient suffer physical injury in order to recover for lack of informed consent is that the patient must prove that the injury resulted from the procedure that the doctor performed and not from some other source, such as the patient's underlying illness or injury.[23] This requirement is referred to as "injury causation."[24]

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[15] See Canterbury v. Spence, 464 F.2d 772, 786 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Walker v. North Dakota Clinic, 415 F. Supp. 891, 895 (D.N.D. 1976); Sawyer v. Methodist Hosp. of Memphis, 383 F. Supp. 563, 566 (W.D. Tenn. 1974). *See also* Delaune v. Davis, 316 So.2d 7, 12 (La. Ct. App. 1975); Jeffries v. McCague, 242 Pa. Super. 76, 84-85, 363 A.2d 1167, 1171 (1976).

[16] Ficklin v. MacFarlane, 550 P.2d 1295, 1297 (Utah 1976); Thomas v. Berrios, 348 So.2d 905 (Fla. Dist. Ct. App. 1977).

[17] See Watson v. Clutts, 262 N.C. 153, 136 S.E.2d 617, 621 (1964).

[18] Reidinger v. Colburn, 362 F. Supp. 1073, 1076 (D. Idaho 1973).

[19] Ficklin v. MacFarlane, 550 P.2d 1295, 1296 (Utah 1976).

[20] See, e.g., Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116, 120 (1970).

[21] See Joseph Goldstein, *For Harold Lasswell: Some Reflections on Human Dignity, Entrapment, Informed Consent, and the Plea Bargain*, 84 YALE L.J. 683, 691 & *passim* (1975) (criticizing this view).

[22] See, e.g., Cornfeldt v. Tongen, 262 N.W.2d 684, 699 (Minn. 1977).

[23] Courts and legislatures that have explicitly recognized this requirement have sometimes done so under the aegis of "proximate cause." See, e.g., Tvedt v. Haugen, 70 N.D. 338, 294 N.W. 183, 189 (1940); Belcher v. Carter, 13 Ohio App.2d 113, 234 N.E.2d 311, 312 (1967); Congrove v. Holmes, 308 N.E.2d 765, 769 (Ohio C.P. 1973); Francis v. Brooke, 24 Ohio App. 136, 140, 5 Abs. 25 (1926); NEB. REV. STAT. § 44-2820(2) (1978); N.Y. PUB. HEALTH LAW § 2805-d(3) (McKinney 1977); N.D. CENT. CODE § 26-40.1-05 (1978); TENN. CODE ANN. § 23-3414(a)(3) (Cum. Supp. 1979); WASH. REV. CODE ANN. § 7.70.050(1)(d) (Supp. 1977). Some of the statutes require that the plaintiff demonstrate "proximate cause" in order to recover. In some, this requirement occurs in combination with a requirement that the plaintiff demonstrate "decision" causation. *See, e.g.*, N.Y. PUB. HEALTH LAW § 2805-d(3) (McKinney 1977). Thus, in such statutes proximate cause must

Finally, another aspect of legal causation is that the patient must prove that nondisclosure or inadequate disclosure was responsible for the decision to undergo the treatment that caused the injury. There has been a great deal of discussion about whether or not this kind of causation—"decision causation"[25]—is to be determined by reference to an objective or subjective standard. Under the former, the factfinder is required to determine that a reasonable person in the patient's situation would not have consented to treatment if proper disclosure had been made. Of the jurisdictions that have specifically confronted the issue, almost all have adopted this standard of causation. By contrast, the subjective standard of causation permits the patient to recover for lack of informed consent if the patient is able to convince the jury that he or she would have refused treatment if disclosure had been adequate, which ordinarily requires only that the patient so testify. Although several courts and legislatures have employed language in cases and statutes that suggest that they are adopting a subjective standard,[26] most of these law-making bodies seem unaware of the controversy, and thus it is difficult to be sure that if specifically confronted with the issue, they actually would adopt a subjective standard. Only one court that has adopted a subjective standard explicitly discussed what it was doing.[27]

Consent. The focus of law-making by courts has been almost exclusively on physicians' duty to inform patients. Little has been written by courts in the last two decades about the duty to obtain consent other than the bare mandate that it be obtained.[28]

It is well established that consent need not be obtained in written form in order to be effective, though physicians and hospital administrators seem to prefer the use of consent

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refer to "injury" causation. Other statutes contain a proximate cause requirement as well as a requirement that the plaintiff prove injury causation; see, e.g., N.H. REV. STAT. ANN. § 507-C:2(I)(c) (Supp. 1977), in which case proximate cause must refer to decision causation.

[24] See Meisel and Kabnick, *supra* note 6, at 438-39.

[25] *Id.* at 439-41.

[26] *See, e.g.*, Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676, 690 (1972); ALASKA STAT. § 9.55.556(b)(2) (Cum. Supp. 1978).

[27] Scott v. Bradford, 606 P.2d 554, 559 (Okla. 1980).

[28] A few courts have expressly stated that consent need not be obtained in writing. See, e.g., Hernandez v. United States, 465 F. Supp. 1071, 1073 (D. Kan. 1979); Maercklein v. Smith, 129 Colo. 72, 266 P.2d 1095, 1099 (1954): A few others have discussed the legal effect that written consent is to have. See, e.g., Zaretsky v. Jacobson, 126 So.2d 757, 58-59 (Fla. Dist. Ct. App. 1961); Luna v. Nering, 426 F.2d 95, 98-99 (5th Cir. 1970); Karp v. Cooley, 349 F. Supp. 827, 835 (S.D. Tex. 1972); Goodnight v. Phillips, 458 S.W.2d 196, 200 (Tex. Civ. App. 1970); Rea v. Gaulke, 442 S.W.2d 826, 829 (Tex. Civ. App. 1969); Drummond v. Hodges, 417 S.W.2d 740, 747-48 (Tex. Civ. App. 1967); Jeffcoat v. Phillips, 417 S.W.2d 903, 905-06 (Tex. Civ. App. 1967).

forms—sometimes labeled "informed" consent forms[29]—as documentation. The informed consent statutes deal with this aspect at greater length, but in a formalistic way. A number of the statutes contain provisions concerning the effect that obtaining consent from the patient in writing is to have, which is generally that a written consent creates some sort of legal presumption that consent has been given.

What the effect of this "presumption" is in practical terms is not clear, and it may amount to little.[30] The Supreme Court of North Dakota has spoken most intelligently on this matter; it said:

> The fact that the patient may have signed a consent form is relevant and material to the determination of whether the doctor had fulfilled his duty to disclose but is not binding upon the patient if . . . the patient did not have the information necessary to make . . . an informed consent.[31]

None of the statutes and none of the cases (except occasionally in passing) deal with the difficult issue of ascertaining whether patients understand the information that is to be provided to them.

Defenses

The plaintiff (i.e., the patient) in an informed consent case has the burden of pleading that disclosure was inadequate and/or that consent was not obtained, as well as the burden of producing sufficient evidence of these matters to survive a directed verdict. Once that has been done, the physician-defendant may choose to dispute the patient's evidence about the adequacy of disclosure,[32] or may take a different tack, in effect admitting that disclosure was inadequate and seeking to justify that course.

Justification for less than adequate disclosure may be found in any one of the four recognized exceptions to the requirement of informed consent: (1) the emergency exception,

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[29] See Goldstein, *supra* note 21, at 692: "[A]voiding [liability] seems to be a primary concern of those who draft what are strangely called 'informed consent forms'. . . ."

[30] See Meisel and Kabnick, *supra* note 6, at 467 *et seq.*

[31] Wasem v. Laskowski, 274 N.W. 2d 219, 226 (N.D. 1979).

[32] A dispute about the adequacy of disclosure may take two forms: factual or legal. In the first, the physician may provide evidence that he or she has provided the patient with more information than the patient claims. Or the physician may admit that he or she provided the information that the patient claims was received, but seek to show that that information was "adequate." Such a defense is more likely to be utilized in jurisdictions adhering to a professional standard of disclosure.

(2) incompetency, (3) waiver, and (4) therapeutic privilege.[33] When one of these exceptions is properly invoked, the legal duties to make disclosure and obtain consent are relaxed or dispensed with entirely. The law in most jurisdictions has not addressed the effect that a particular exception has on the dual obligations that informed consent imposes on physicians. Logically, some of the exceptions ought to relieve the physician only of the duty of disclosure but should still require that consent be obtained; others should relieve the physician of the duty to obtain consent, but might still require disclosure; and in other situations, a physician might be relieved of both obligations.

The legal status of the exceptions is ambiguous in many jurisdictions. The outcome of only a very few informed consent cases has turned on the definition or application of an exception. Rather, most of the discussion in the case law about the exceptions is *obiter dictum*. Yet the logic of the informed consent doctrine makes it almost certain that any court would hold that each and every one of the four exceptions was a part of the corpus of the law of that jurisdiction, when properly presented with the question. Thus, the fact that a given jurisdiction has not affirmatively recognized a particular exception, or has recognized it only in dictum, should not be understood as denoting that the exception does not "exist" in the law of that jurisdiction. Equally compelling is the fact that no reported case has ever refused to recognize the existence of any of the four exceptions, though of course courts have found that under the facts of particular cases, a claimed exception did not apply.

Emergency. In an emergency, when the need for the immediate rendition of medical care exists, a doctor is excused from having to make disclosure and obtain consent. As simple as the rule is to state, it is equally difficult to apply. Medical care does not fall neatly into two precise categories of "emergency" and "nonemergency." The degree of urgency with which a procedure needs to be performed can vary substantially. As a result, in some instances a physician may have sufficient time to seek a patient's (or a surrogate's) permission to perform a procedure, but inadequate time to make the ordinarily required disclosure without seriously jeopardizing the patient's life or health. In other instances there may be time to make abbreviated disclosure but not to the same extent as required if delay did not jeopardize the patient's well-being. Although many courts have recognized the existence of the emergency exception, few if any have had occasion to undertake a thorough discussion of how an emergency ought to affect physicians' dual obligations.

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[33] In addition to these exceptions, a doctor is usually not required to disclose remote, minor, common, known, or usual risks. Although these are more properly treated as a refinement of the standard of disclosure, they might also be seen as exceptions. Because the structure of many informed consent statutes tends to classify them as exceptions, the Tables that follow classify them as exceptions, though the burden of proof is properly on the plaintiff.

Incompetency. An individual who is legally incompetent lacks the legal authority to grant permission for the rendition of his or her own medical care. In practice, aside from children (for whom special legislative provisions have often been made[34]) very few people have been adjudicated incompetent. However, there are probably far more individuals whose *de facto* capacity to make a decision about a particular medical procedure may be seriously compromised. Although case law and statutes recognize this by providing that informed consent need not be obtained from such individuals, they are usually unhelpful in assisting practitioners to, first, identify what degree of impairment of decisionmaking capacity is needed before a patient's informed consent need not be obtained and, second, determine from whom informed consent should be obtained when a patient lacks decisionmaking capacity. Furthermore, there is no guidance about the extent to which patients who lack decisionmaking capacity ought to be given information even if they are not fully able to comprehend it, appreciate its significance, and use it in decisionmaking; or whether a patient who lacks capacity but is able to express a preference for or against treatment ought to be able to influence the decisionmaking. Again, the outcome of few cases turns on the application of this exception, and hence there is very little authoritative guidance on any of these questions.[35]

Waiver. Some patients may prefer not to be told very much, or even anything, about a proposed medical procedure. The informed consent doctrine merely requires physicians to offer to make information available to patients; it does not require or even permit physicians to force information on unwilling patients.[36] Other patients, after receiving information to which they are entitled, may find that they are unable or do not wish to make a decision about treatment, and may prefer instead to have the physician decide. Both of these preferences—not to be informed and/or not to decide—are recognized in the waiver exception. Although several cases recognize and discuss this exception, the outcome of no case turns on it. As a result, courts have not had occasion to spell out the requisities of a valid waiver of either or both of the doctor's duties. Waiver, however, is recognized in other areas of law from which some guidance may be drawn in the medical context.[37]

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[34] A. M. Capron, *The Competence of Children as Self-Deciders in Biomedical Interventions*, in Willard Gaylin and Ruth Macklin, WHO SPEAKS FOR THE CHILD, New York, Plenum Press (1982) at 57, 95-114.

[35] There is increasing litigation over these issues when decisions to withhold life-sustaining treatment are involved. See the Commission's report on decisions to forego life-sustaining treatment.

[36] In fact, patients may have a cause of action against physicians for disclosing information that they do not wish to hear. *Cf.* Ferrara v. Galluchio, 5 N.Y.2d 16, 176 N.Y.S.2d 996, 152 N.E.2d 249 (1958) (recognizing a cause of action for the disclosure by a doctor to a patient of frightening information).

Therapeutic privilege. Therapeutic privilege is undoubtedly the most discussed and debated of the four exceptions, though again the outcome of few if any cases seems to turn on its application.[38] The exception is formulated by courts and legislatures in a variety of ways, so that it is difficult, if not impossible, to capture the essence of the privilege succinctly. The formulations range from the fairly vague to the specific. In Rhode Island, "the physician [is required] to disclose . . . unless the doctor makes an affirmative showing that nondisclosure was in the best interests of the patient."[39] More specific is the formulation employed in Kansas: "If a complete disclosure of all facts, diagnoses, and possible alternatives would endanger the recovery of the patient because of his existing physical or mental condition, the physician may withhold such information."[40] These formulations, and others, focus on the anticipated effect that ordinarily required disclosure would have on the patient, and reflect the importance ascribed to the physician's "primary duty to do what is best for the patient," as the Supreme Court of North Carolina put it in formulating that state's therapeutic privilege.[41]

A few courts have focused instead, or in addition, on the effect that the disclosure of frightening information might have on the patient's decisionmaking capabilities. Thus, in addition to other reasons, the Minnesota Supreme Court concluded that the therapeutic privilege is applicable "if disclosure of the information would . . . cause such emotional distress as to preclude a rational decision" by the patient.[42] This formulation is most in keeping with the dual goals of informed consent of maximizing the patient's well-being and encouraging autonomous decisionmaking by the patient.

Finally, other courts, contrary to these goals of informed consent, have held that a physician has a privilege to withhold information that "risk[s] frightening the patient out of a course of treatment which sound medical judgment dictates the patient should undertake. . . ."[43] This and similar formulations of the privilege ignore the caution issued by the Court of Appeals for the District of Columbia in the leading informed consent case, Canterbury v. Spence: "The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself."[44]

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[37] See Alan Meisel, The "Exceptions" to the Informed Consent Doctrine: *Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 453-60.

[38] Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116 (1970), may be the only one.

[39] Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676, 687-88 (1972); *accord*, Holt v. Nelson, 11 Wash. App. 230, 523 P.2d 211, 218 (1974).

[40] Tatro v. Lueken, 212 Kan. 606, 512 P.2d 529, 537 (1973).

[41] See Watson v. Clutts, 262 N.C. 153, 136 S.E.2d 617, 621 (1964).

[42] Cornfeldt v. Tongen, 262 N.W.2d 684, 700 (Minn. 1977); *accord*, Bly v. Rhoads, 222 S.E.2d 783, 787 (Va. 1976).

Unlike the other exceptions in which it is clear that the burden of proof is on the physician who is asserting the appropriateness of invoking an exception, the burden of proof on the therapeutic privilege is not always so clear. In those jurisdictions that abide by a patient-oriented standard of disclosure, the burden is clearly on the physician. However, in jurisdictions governed by a professional standard of disclosure, the question of the extent of required disclosure is so closely bound up in the same sorts of issues that must be proved to establish the therapeutic privilege that it may be that the patient-plaintiff should, or in effect does, bear the burden of proof. In fact, it is not really clear that in such jurisdictions there is a therapeutic privilege distinct from the standard of disclosure.[45]

Surrogate Decisionmaking

Although strictly speaking not an aspect of the informed consent doctrine, the problem of surrogate decisionmaking for patients who lack decisional capacity is closely related. In situations in which the incompetency exception is invoked, informed consent ought to be obtained from the patient's legally authorized representative.[46] Failure to do so, absent an emergency, is grounds for an action in battery. Where information is withheld from a patient under the aegis of the therapeutic privilege, there is some suggestion in the case law that disclosure should be made to a third party, though there is suggestion in other cases that such disclosure is either unnecessary or improper.[47] Another reason to discuss surrogate decisionmaking in connection with informed consent is that a number of the informed consent statutes deal with the matter, some rather comprehensively by providing a list and order of preference of relatives of a patient who are empowered to consent in the event of a patient's decisional incapacity, others less satisfactorily (as is often the situation in the case law) by merely mentioning that consent should be sought from a representative of the patient when the patient is unable to consent.

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[43] Thomas v. Berrios, 348 So.2d 905, 907 (Fla. Dist. Ct. App. 1977); *cf.* Hales v. Pittman, 118 Ariz. 305, 576 P.2d 493, 499 n.4 (1978).

[44] Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir. 1972).

[45] "The therapeutic privilege not to disclose . . . is merely a procedurally different way of invoking the professional standard of care." Jay Katz, *Informed Consent: A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 156 (1977).

[46] See, e.g., Darrah v. Kite, 32 App. Div.2d 208, 212, 301 N.Y.S.2d 286, 292 (1969); Koury v. Follo, 272 N.C. 366, 158 S.E.2d 548 (1968).

[47] See Meisel, *supra* note 37, at 465-66.

Testimony and Form of Action

Expert Testimony. Expert testimony from professionally qualified witnesses is needed to establish some of the elements of the cause of action for lack of informed consent or to establish a recognized defense. There are some fairly simple rules for determining when expert testimony is needed.[48] Those jurisdictions that subscribe to a professional standard of care ordinarily require that the plaintiff-patient establish the standard and its breach through the use of expert testimony.[49] In jurisdictions that have adopted a patient-oriented standard, no expert testimony is needed to establish what is adequate disclosure in a particular case.

Expert testimony is also needed in all jurisdictions to establish injury-causation, that is a causal link between the procedure or treatment the doctor administered and the injury the patient suffered. Expert testimony may also be needed in either a professional- or lay-standard jurisdiction to establish what the risks of a particular treatment are (which is closely related to proof of injury-causation) and, when the patient claims that the physician failed adequately to disclose alternatives, what the alternatives were.

In theory, expert testimony may also be needed to establish that the circumstances were appropriate for the invocation of an exception to informed consent, but in practice, the courts have only spoken on the need for expert testimony to establish the therapeutic privilege.[50] In establishing that circumstances urgently required the provision of treatment, or that the patient was not capable of understanding, appreciating, or using the information that would have been disclosed, a court might also require that the defendant provide expert evidence. It is far less likely that there is much, if any, role for expert testimony to play in the establishment of the appropriateness of invoking the waiver exception.

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[48] Because the rules on the need for expert testimony are relatively consistent from jurisdiction to jurisdiction, this information is not summarized in the Tables that follow.

[49] A notable exception is Colorado, where after the plaintiff makes out a prima facie case by introducing evidence of what was disclosed, the defendant-physician is obligated (at the risk of a directed verdict) to produce expert evidence of what the proper standard of disclosure is. See Mudd v. Dorr, 574 P.2d 97, 101 (Colo. App. 1978).

[50] In those jurisdictions in which the burden of proof is on the physician to establish the therapeutic privilege (i.e., ordinarily where there is a lay standard of disclosure), the physician, as an expert, may be able to establish the appropriateness of invoking the privilege without having to obtain the services of another expert. Similarily, in any matter that the plaintiff must establish by expert testimony, the defendant's testimony may be used by the plaintiff, though it will often not be tactically wise to do so.

Form of Action. For a number of years there was a great deal of controversy over the proper form of action, but it is now settled in every jurisdiction having considered the matter that the proper form of action for nondisclosure or inadequate disclosure, where the patient has consented to treatment, is negligence, and that battery is appropriate only where "the treatment consists of a touching that is of substantially different nature and character from that to which the patient consented."[51] Thus, claims for lack of informed consent should ordinarily be brought in negligence, except possibly in those jurisdictions that have not ruled on the issue, in which an excess of caution counsels that the claim be brought both in negligence and in battery.

Highlights of State Law

The tables that follow summarize the major features of the law of informed consent for every state[52] and the District of Columbia—namely, (1) the standard of disclosure, (2) the standard of causation, (3) the exceptions, (4) surrogate decisionmaking, and (5) the effect of obtaining written consent. The law is ordinarily presented by quotations from leading cases or from statutes,[53] with the source provided after the quotation.[54] The full citations to the leading cases (not all of which are used in the tables) and statutes (where appropriate) appear after the tables. As mentioned, physicians are excepted from disclosing minor, remote, common, known, or usual risks to treatment. Although these fall conceptually within the definition of the standard of care and/or the elements of disclosure (which is merely is refinement of the standard of care), the tables that follow list these exclusions under "defenses" since lawmakers—especially legislators—tend to present and discuss them in that manner.[55]

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[51] Cornfeldt v. Tongen, 262 N.W.2d 684, 699 (Minn. 1977). Because of the unanimity of view about this matter, this information is not included in the following Tables.

[52] In three states, there is neither any reported decisional law nor statutory law of informed consent. See note 4 *supra*.

[53] Excluded from consideration in the compilation of these tables are specialized statutes dealing with consent to medical care for children or the mentally disabled, and for procedures dealing with reproduction (abortion, sterilization, and contraception), as well as compulsory treatment laws.

[54] In some cases, instead of quoting applicable language, the symbol "i" appears, indicating that the provision of informed consent in question is implied by the designated case or statute, but that there is no precise or brief language appropriate for quotation.

[55] See note 33 *supra*.

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
ALABAMA			"[T]he anxiety, apprehension, and fear generated by a full disclosure . . . may have a very detrimental effect on some patients." Roberts v. Wood p.583		
ALASKA § 09.55.556	"[C]ommon risks and reasonable alternatives" § 09.55.556(a)	"[B]ut for [disclosure] the claimant would not have consented" § 09.55.556(a)	"It is a defense . . . that (1) the risk not disclosed is too commonly known or is too remote to require disclosure; (2) the patient stated to the health care provider that he would undergo the treatment or procedure regardless of the risk involved or that he did not want to be informed of the matters to which he would been entitled to be informed; (3) under the circumstances consent by or on behalf of the patient was not possible; or (4) the health care provider after considering all of the attendant facts and circumstances used reasonable discretion as to the manner and extent that the alternatives or risks were disclosed to		

			the patient because he reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition." § 09.55.556(b)			
ARIZONA §§ 12-561 to 12-563	"[T]hat degree of care, skill and learning expected of a reasonable, prudent health care provider . . . within the state in the same or similar circumstances." 12-563(1); *accord* Gaston v. Hunter p.350	"[F]ailure [to exercise reasonable care] was a proximate cause of the injury" 12-563(2) "Proof of proximate cause is upon the plaintiff. . . . The fact that the [patient] proceeded to have this operation . . . after she was . . . informed . . . is some evidence that disclosure . . . would not have deterred her. . . . The risks of injury are not so great as to cause most reasonable persons to decline to have such a beneficial operation performed." Shetter v. Rochelle p.74	"A physician is not required to disclose every possible minor risk associated with a proposed procedure. . . . To do so conceivably could frighten the patient away from needed therapy or possibly result in psychosomatic ramifications." Hales v. Pittman p.499 n.4			
ARKANSAS §§ 34-2613 to 34-2614	"[T]hat type of information as would customarily have been given to a patient in	"Whether the injured party would have undergone the treatment	"[W]here the plaintiff claims that a medical care provider failed to supply	i - § 34-2614 (B)(2)(b)		

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
ARKANSAS (cont.)	the position of the injured person . . . in the locality in which the medical care provider practices or in a similar locality" § 34-2614(b)(1)	. . . regardless of the risk involved . . . shall be considered as [a] material issue. . . ." § 34-2614(B)(2)(c)	adequate information to obtain the informed consent of the injured person . . . the plaintiff shall have the burden of proving that the treatment, procedure or surgery was performed in other than an emergency situation. . . ." § 34-2614(B)(1) "Whether a person of ordinary intelligence and awareness in a position similar to that of the injured person . . . could reasonably be expected to know of the risks" § 34-2614(B)(2)(a) "Whether the injured party . . . did not wish to be informed [of the risk of treatment]" § 34-2614(B)(2)(c)		
CALIFORNIA	"When there is a common procedure a doctor must . . . make such inquiries as are required to determine if for the particular patient the treatment under consideration is contraindicated. . . .; but no warning beyond such inquiries is required as to	"[C]ausal connection arises only if . . . had revelation been made consent to treatment would not have been given. . . . An objective test is preferable: i.e., what would	"A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent." Cobbs v. Grant p.10	"[I]f the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or closest available	

	the remote possibility of death or serious bodily harm. . . . When there is a more complicated . . . procedure the jury should be instructed that when a given procedure inherently involves a known risk of death or serious bodily harm, a medical doctor has a duty to disclose to his patient the potential of death or serious harm, and to explain in lay terms the complications that might possibly occur. Beyond the foregoing minimal disclosure, a doctor must also reveal to his patient such additional information as a skilled practitioner of good standing would provide under similar circumstances. . . . The scope of the physician's communications to the patient . . . must be measured by the patient's need, and that need is whatever information is material to the decision." Cobbs v. Grant p.11	a prudent person in the patient's position have decided if adequately informed of all significant perils." Cobbs v. Grant p.11-12	"[A] medical doctor need not make disclosure of risks when the patient requests that he not be so informed. . . . Such a disclosure need not be made if the procedure is simple and the danger remote and commonly appreciated to be remote. A disclosure need not be made beyond that required within the medical community when . . . the disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of the recommended treatment. . . . Any defense . . . must be consistent with . . . the 'fiducial qualities' of the physician-patient relationship." Cobbs v. Grant p.12 "[A] medical doctor need not make disclosure of risks when the patient requests that he not be so informed." Cobbs v. Grant p.12; of Putenson v. Clay Adams Inc. p.333.	relative." Cobbs v. Grant p.10.		
COLORADO	"The precise scope of the physician's duty of dis-	"[The] right to recover must be re-	"Since the extent of disclosure is a medical judg-			

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
COLORADO (cont.)	closure is determined on the basis of expert testimony demonstrating the extent of information given by reasonably careful physicians practicing the same specialty in the same or similar community." Bloskas v. Murray p.914 "Once the patient evinces that she was uninformed, the physician defendant has the burden to go forward and by expert testimony demonstrate that his failure to disclose was in conformity with community medical standards." Mudd v. Dorr p.101	solved on an objective basis, *i.e.*, what would a reasonable person in the plaintiff's position have decided if adequately informed?" Hamilton v. Hardy p.1105	ment, a showing that nondisclosure of certain facts complies with the community standard is a valid defense." Stauffer v. Karabin p.865		
CONNECTICUT	No Common Law or Statute				
DELAWARE title 18 §§ 6801, 6852-53	"Information . . . customarily given to patients . . . by other licensed health care providers with similar training and/or experience in the same or similar health care communities." § 6852(a)(2)		"No recovery . . . shall be allowed . . . unless the injury alleged involved a nonemergency treatment, procedure or surgery." § 6852(s)(1) "[I]t shall be a defense . . . that:		

			(1) A person of ordinary intelligence and awareness in a position similar to that of the injured party could reasonably be expected to appreciate and comprehend hazards inherent in such treatment; (2) The injured party assured the health care provider he or she did not want to be given the information or any part thereof to which he or she would otherwise be entitled; or (3) It was reasonable for the health care provider to limit the extent of his or her disclosure of the risks of the treatment, procedure or surgery . . . because further disclosure could be expected to affect, adversely and substantially the injured party's condition, or the outcome of the treatment, procedure or surgery." § 6852(b)		
DISTRICT OF COLUMBIA	"The scope of the standard is . . . objective with due regard for the patient's informational needs and with suitable leeway for the	"A causal connection exists when, but only when, disclosure of significant risks incidental to	"[W]hen the patient is unconscious or otherwise incapable of consenting . . . When a genuine emergency of that sort arises, it is	"[E]ven in a situation of that kind [in which the therapeutic privilege is	

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
DISTRICT OF COLUMBIA (cont.)	physician's situation. . . . 'A risk is . . . material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.' " Canterbury v. Spence p.787 *but see* Haven v. Randolph p.544 ("there has been no expert medical evidence or any other evidence put forward . . . that [the doctor's] omission of reference to the risk . . . was a deviation from the standard of care")	treatment would have resulted in a decision against it. . . . Better it is . . . to resolve the causality issue on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance." Canterbury v. Spence pp.790-91	settled that the impracticability of conferring with the patient dispenses with the need for it. . . ." Canterbury v. Spence p.788 The second exception obtains when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. . . . Where that is so . . . the physician is armed with a privilege. [This privilege] to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself." Canterbury v. Spence p.789 "[T]here is no obligation to communicate those [dangers] of which persons of average sophistication are aware. Even more clearly, the physician bears no responsibility for discussion of hazards the patient has	appropriately invoked], disclosure to a close relative with a view to securing consent to the proposed treatment may be the only alternative open to the physician." Canterbury v. Spence p.789 "Where the complaint in suit is unauthorized treatment of a patient legally or factually incapable of giving consent, the established rule is that, absent an emergency, the physician must obtain the necessary authority from a relative."	

			already discovered.” Canterbury v. Spence p.788 “[P]hysicians and courts alike must accept the patient’s election to know nothing and instead to rely completely upon physician, . . . for the patient . . . is free to unwisely act in the dark so long as he is exercising his own ‘right of self-determination.’ ” Henderson v. Milobsky p.656 n.8	Canterbury v. Spence p.789 n.92	
FLORIDA § 768.46	“No recovery . . . in an action . . . for treating . . . without informed consent when the action of the [doctor] in obtaining . . . consent . . . was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community.” § 768.46(3)(a)(1)	“No recovery . . . in an action . . . for treating . . . without informed consent when . . . the patient would reasonably, under all the surrounding circumstances, have undergone such treatment . . . had he been [properly] advised.” § 768.46(3)(b)	“A valid signature is one which is given by a person who under all surrounding circumstances is mentally and physically competent to give consent.” § 768.46(4)(b) “The doctrine of informed consent does not require the doctor to risk frightening the patient out of a course of treatment which sound medical judgment dictates the patient should undertake.” Thomas v. Berrios p.907	i - § 786.46 (3)(a)(1), (4)(a)	A consent which is evidenced in writing and meets [previously stated] requirements shall, if validly signed by the patient . . . be conclusively presumed to be a valid consent. This presumption may be rebutted if there was a fraudulent misrepresentation of a material fact in obtaining the signature.” § 768.46(4)(a)

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
FLORIDA (cont.)			" '[W]here the emergency endangers the life or health of the patient, it is the surgeon's duty to do that which the occasion demands within the usual and customary practice among physicians and surgeons in the same or similar localities, without consent of the patient***'." Chambers v. Nottebaum p.718		
GEORGIA §§ 88-2901 to 88-2907	"[I]n general terms the treatment or course of treatment" 88-2906; "This duty does not include a disclosure of the 'risks of treatment. . . .' " Young v. Yarn p.114		"[C]onsent . . . will be implied where an emergency exists. . . ." § 88-2905 i - § 88-2904 (incompetency)	"[A]ny one of the following persons is authorized and empowered to consent. . . ." § 88-2904	"Any consent . . . which discloses in general terms the treatment or course of treatment in connection with which it is given and which is duly evidenced in writing and signed by the patient . . . shall be conclusively presumed to be a valid consent in the absence of fraudulent misrepresentation of material facts in obtaining the same." § 88-2906; *cf.* Winfrey v. Citizens & Southern National Bank p.728
HAWAII § 671-3; Regs	"The board of medical examiners shall, insofar as practicable, establish rea-		"In any action . . . based on informed consent, evidence may be introduced	"In the case of a mentally incompetent per-	"If a patient . . . signs a correctly completed consent form or refusal of informa-

§§ 16-85-24 to -28	sonable standards of medical practice, applicable to specific treatment or surgical procedures, for the substantive content of the information required to be given and the manner in which it is given . . . in order to constitute informed consent." § 671-3(b); R 16-85-25		that the health care provider complied with standards . . . governing the information to be given . . . to . . . the patient's guardian in the case of a patient who is not competent to give informed consent." § 671-3(a); Nishi v. Hartwell p.122 "Nothing in this section shall require informed consent from a patient or patient's guardian when emergency treatment or emergency surgical procedure is rendered . . . and the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of the patient's health." § 671-3(c); cf Nishi v. Hartwell p.119 "A patient may elect not to be informed of part or all of the information required to be disclosed. . . ." R 16-85-27	son, the person duly authorized to act for him is his legal guardian . . . ." Nishi v. Hartwell p.122; *cf.* 671(3)(a); R 16-85-28	tion form . . . the . . . form shall be prima facie evidence that the patient gave informed consent . . . or has refused to receive the information. . . ." R 16-85-28
IDAHO §§ 39-4301 to 39-4306	"[S]uch disclosures and . . . advice respecting pertinent facts and considerations as would ordinarily be made and given under the	"[W]hat would a reasonably prudent person have decided if informed to the same extent as [plain-	"Whenever there is . . . a medical emergency or there is substantial likelihood of [a patient's] life or health being seriously endangered	"Consent for the furnishing of . . . care . . . to any person who is not then capa-	"It is not essential to the validity of any consent . . . that the same be in writing. . . .; however, when . . . in writing . . . and

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
IDAHO (cont.)	same or similar circumstances, by a . . . [doctor] . . . practicing in the same community. . . ." § 39-4304	tiff]. . . ." Riedinger v. Colburn p.1078	by withholding or delay in the rendering of . . . care . . ., the attending [doctor] may . . . authorize and/or provide such care. . . ." § 39-4304(c) "Any person of ordinary intelligence and awareness sufficient for him or her generally to comprehend [relevant information] is competent to consent. . . ." § 39-4302	ble of giving such consent . . . may be given or refused by any competent parent, spouse, or legal guardian . . . unless the patient is a competent adult who has refused to give such consent. . . ." § 39-4303(a) "If no parent, spouse, or legal guardian is readily available to do so, then consent may be given by any competent relative. . . ." § 39-4303(b)	executed or initiated by a person competent to give such consent, in the absence of . . . fraud is presumed to be valid. . . ." § 39-4305; *cf.* § 39-4304
ILLINOIS	"[P]laintiff ha[s] the burden of providing by expert medical evidence that the reasonable medical practitioner of the same school, in the same or similar circum-		"A doctor has a special relationship with his patient. . . . This relationship . . . requires the doctor to exercise discretion in prudently disclosing informa-		

	stances, would have told the patient of such risks, or that the disclosure as made by the defendants did not meet the standard of what a reasonable medical practitioner would have disclosed under the same or similar circumstances." Green v. Hussey p.161		tion in accordance with his patient's best interests. To disclose more than that which is material would run counter to the responsibility assumed through the doctor-patient relationship." Miceikis v. Field p.324; *cf.* Carman v. Dippold p.1370		
INDIANA	"[It is clear that there is a] duty of a physician to make a reasonable disclosure of material facts relevant to the decision which the patient is requested to make." Joy v. Chau pp.676-677 "The general rule is that expert medical testimony is required to establish the content of . . . 'reasonable disclosure' unless the situation is so obvious that laymen could recognize the necessity of such disclosure." Revord v. Russell p.764	"There is no proximate cause if the plaintiff would have submitted to the treatment even if a full disclosure had been made."			
IOWA § 147.137	"How a physician chooses to discharge his obligations to a patient involves primarily a question of medical judgment. . . ." Grosjean v. Spencer p.145	"[R]ecovery is precluded unless a [patient] establishes he would not have submitted to the procedure if he had been advised of the	incompetency: i - § 147.137(3) " 'To make a complete disclosure of all facts, diagnoses and alternatives or possibilities which might	i - § 147.137(3)	"A consent in writing to any medical or surgical procedure or course of procedures . . . which meets the requirements of this section shall create a presumption that informed consent

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
IOWA (cont.)		risk. . . ." Perin v. Hayne p.618	occur to the doctor could so alarm the patient that it would . . . constitute bad medical practice.' " Grosjean v. Spencer p.144		was given." § 147.137
KANSAS	"[A] physician or surgeon has a legal obligation to make a reasonable disclosure to his patient . . . in order that his patient will have a basis to make an intelligent informed consent to the proposed treatment. But the duty . . . is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances." Funke v. Fieldman p.541	"A causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it. . . . Whether a patient would have refused treatment or a medical procedure had the physician made adequate disclosure is to be determined objectively." Funke v. Fieldman pp.549, 550	"In the absence of an emergency a physician or surgeon has a legal obligation to make a reasonable disclosure. . . ." Funke v. Fieldman p.541 "If a complete disclosure of all facts, diagnoses, and possible alternatives would endanger the recovery of the patient because of his existing physical or mental condition, the physician may withhold such information.' " Tatro v. Lueken p.537 "[T]he duty of a physician or surgeon [does not extend] to the extreme where he would have to apprise his patient not only of the known risks but also of each infinitesimal, imaginative, or speculative element that would go into making up	"[I]f the patient is incompetent the consent must be obtained from someone legally authorized to give it for him." Younts v. St. Francis Hosp & School of Nursing p.336	

			such risks." Yeates v. Harms p.991		
KENTUCKY § 304.40-320	"The action of the health care provider in obtaining the consent of the patient . . . was in accordance with the accepted standard of medical . . . practice among members of the profession with similar training and experience. . . ." § 304.40-320(1)		"In an emergency situation where consent of the patient cannot reasonably be obtained before providing health care services, there is no requirement that a health care provider obtain a previous consent." § 304.40-320(3); *accord* Tabor v. Scobee pp.475-476	"In surgical cases, consent to such procedure must be obtained from either the patient, or, if the patient is under some disability, from a near relative capable of giving consent." Wilson v. Lehman p.479-80; i § 304.40-320(1)	[T]he [patient's] informed consent shall be deemed to have been given where [the requirements of the statute have been met]. . . ." § 304.40-320
LOUISIANA § 40:1299.40, 1299.53, 1299.54	"[I]n general terms the nature and purpose of the procedure or procedures, together with [certain kinds of] known risks. . . ." § 1299.40(A) "[D]uty of disclosing all known risks material to the patient's decision and, given the risks, the trier of fact is competent to decide, without the aid of experts, whether the risks were material and should have been disclosed." Percle v. St Paul	"[A]n objective test in establishing causation, meaning what a prudent person in plaintiff's position would have decided if adequately informed." Percle v. St Paul Fire & Marine Ins Co. p.1300 "[D]isclosure . . . would have resulted in a decision against [the choice that the patient actually	"[A]ny delay in treatment could reasonably be expected to jeopardize the life or health of the person affected, or could reasonably result in disfigurement or impair faculties." § 1299.54; *accord* Rogers v. Lumbermen's Mutual Casualty Co. p.650 "When the patient is unconscious and otherwise incapable of consenting and imminent harm from failure to treat outweighs any pos-	"In addition to such other persons as may be authorized and empowered, any one of the following persons is authorized and empowered to consent, either orally or otherwise, to any surgical or medical treatment or procedures . . . [a	"[W]ritten consent to medical treatment [that makes disclosure in conformance with statutory requirements and] acknowledges that such disclosure . . . has been made and that all questions asked about the procedure . . . have been answered in a satisfactory manner, and is signed by the patient . . . shall be presumed to be valid and effective, in the absence of proof that execution of the consent was induced by misrepresentation

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
LOUISIANA (cont.)	Fire & Marine Ins Co. p.1299	made]. . . ." Reynier v. Delta Women's Clinic p.738	sible ill effects from the proposed treatment. . . ." Percle v. St. Paul Fire & Marine Ins Co. p.1299; "[W]hen disclosure poses such a threat of detriment to the patient as to become unfeasible or inimical to the patient's well-being. . . ." Percle v. St. Paul Fire & Marine Ins Co. p.1299	list of relatives follows]. . . ." § 1299.53; *accord* Percle v. St. Paul Fire & Marine Ins Co. p.1300; *but see* Beck v. Lovell pp.250-51	of material facts." § 1299.40(A)
MAINE title 24 § 2905	"No recovery shall be allowed . . . where . . . the action of the physician in obtaining the consent of the patient . . . was in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities and a reasonable person, from the information provided . . . would have a general understanding of the procedures or treatments and of the usual and most frequent risks. . . ." § 2905(1)(A), (B)	"A reasonable person, under all surrounding circumstances, would have undergone such treatment or procedure had he been [properly] advised. . . ." § 2905(1)(C)	"No recovery shall be allowed . . . where . . . a reasonable person, under all surrounding circumstances, would have undergone such treatment or procedure had he been [properly] advised. . . ." § 2905(1) (C) "A valid consent is one which is given by a person who, under all the surrounding circumstances, is mentally and physically competent to give consent. . . ." § 2905(3) "[W]hen risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or bad	i - § 2905(1)	"A consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient . . . shall be presumed to be a valid consent. This presumption, however, may be subject to rebuttal only upon proof that such consent was obtained through fraud, deception or misrepresentation of material fact. . . ." § 2905(2)

			for the patient's well-being in light of sound medical judgment" Downer v. Veilleux p.91		
MARYLAND	"[T]he scope of the physician's duty to inform is to be measured by the materiality of the information to the decision of the patient. A material risk is one which a physician knows or ought to know would be significant to a reasonable person in the patient's position in deciding whether or not to submit to a particular medical treatment or procedure." Sard v. Hardy p.1022	"[T]he causality requirement . . . is to be resolved by an objective test: whether a reasonable person in the patient's position would have withheld consent . . . had all material risks been disclosed." Sard v. Hardy p.1025	"[T]he physician retains a qualified privilege to withhold information on therapeutic grounds, as in those cases where a complete and candid disclosure of possible alternatives and consequences might have a detrimental effect on the physical or psychological well-being of the patient, or where the patient is incapable of giving his consent by reason of mental disability. . . ., or has specifically requested that he not be told . . . the physician's duty to disclose is suspended where an emergency of such gravity and urgency exists that it is impractical to obtain the patient's consent. . . . [D]isclosure is not required where the risk is either known to the patient or is so obvious as to justify presumption of such knowledge, nor is the physician under a duty to discuss the relatively remote risks inherent in common procedures, when it is common		"[T]he effect to be given to a standard consent form is governed by the same principles used in evaluating [a patient's] claim under the informed consent doctrine. Thus, unless a person has been adequately apprised of the material risks and therapeutic alternatives incident to a proposed treatment, any consent given, be it oral or written, is necessarily ineffectual. . . . In any event, the authorization is simply one additional piece of evidence for the jury to consider in assessing the merits of [the patient's] cause of action for informed consent." Sard v. Hardy p.1019 n.3

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
MARYLAND (cont.)			knowledge that such risks inherent in the procedure are of very low incidence." Sard v. Hardy p.1022		
MASSA-CHUSETTS	"A physician owes to his patient the duty to disclose in a reasonable manner all significant medical information that the physician possesses or reasonably should possess that is material to an intelligent decision by the patient whether to undergo a proposed procedure. . . . What the physician should know involves professional expertise and can ordinarily be proved only through the testimony of experts. . . . However, the extent to which he must share that information with his patient depends upon what information he should reasonably recognize is material to the plaintiff's decision. . . . The materiality determination is one that lay persons are qualified to make without the aid of an expert." Harnish v. Children's Hosp Medical Center	"[T]he plaintiff must . . . show that had the proper information been provided neither he nor a reasonable person in similar circumstances would have undergone the procedure." Harnish v. Children's Hosp Medical Center	"The obligation to give adequate information does not require the disclosure of all risks of a proposed therapy . . . or of information the physician reasonably believes the patient already has, like infection, inherent in any operation." Harnish v. Children's Hosp Medical Center "[S]ound medical judgment might indicate that disclosure would complicate the patient's medical condition or render him unfit for treatment. 'Where that is so . . . the physician is armed with a privilege to keep the information from the patient. . .'." Harnish v. Children's Hosp Medical Center incompetency - i: Lane v. Candura	"[J]udicial approval is required only where life-saving or life-prolonging treatment is to be withheld. . ., and that the traditional consent of family, next of kin, or guardian . . . is [proper] in cases where the medical recommendation is in favor of the administration of such a treatment." *In re* Dinnerstein p.137 n.5; *accord*, Custody of a Minor pp.607-608	

MICHIGAN	"Whether [a physician should advise the patient of all *possible* results] would seem to be a matter to be determined with reference to the general practice customarily followed by the medical profession in the locality." Roberts v. Young p.630 "[T]he defendant may supply the necessary expert testimony." Rice v. Jaskolski p.896		"Courts have resorted to the fiction of implied consent to justify an emergency procedure where there is no opportunity to obtain actual consent." Banks v. Wittenberg p.791; *accord* Franklyn v. Peabody		
MINNESOTA § 144.651	"Failure to disclose a risk that would have been disclosed under accepted medical practice . . . should be a sufficient, but not a necessary, condition of liability. . . . But even if . . . disclosure conforms to accepted medical practice, a physician nevertheless should be liable if he fails to inform the patient of a significant risk of treatment or of an alternative treatment." Cornfeldt v. Tongen I p.702	"[A patient] must show that a reasonable person, had he been informed of the risk, would not have consented to the procedure, . . . also . . . an element of liability is that the undisclosed risk materialize in harm as a result of the treatment." Cornfeldt v. Tongen II p.640	"Exceptions that excuse nondisclosure exist for emergency situations, risks commonly known, and the like." Cornfield v. Tongen I p.700 n.13 "The therapeutic privilege, a[n] . . . exception to the objective standard of disclosure . . . is applicable only if disclosure of the information would complicate or hinder treatment, cause such emotional distress as to preclude a rational decision, or cause psychological harm to the patient." Cornfeldt v. Tongen I p.700	"In cases in which it is not medically advisable to give the information to the patient . . . the information may be made available to the appropriate person in his behalf." § 144.651(2) "In a situation in which nondisclosure is warranted, the physician should seek consent from a close rel-	

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
MINNESOTA (cont.)				ative." Cornfeldt v. Tongen I p.701 n.14	
MISSISSIPPI § 41-41-3 et seq.	"[T]he professional standard according to customs of medical practice . . . in this area. . . ." Ross v. Hodges p.909		"[A] consent to surgical or medical treatment or procedures . . . will be implied where an emergency exists if there has been no protest or refusal of consent by a person authorized and empowered to consent. . . ." § 41-41-7 "[N]othing contained herein shall be construed to abridge any right of an adult who is not of unsound mind . . . to refuse such consent as to his own person. . . . The phraise 'unsound mind' shall also mean and include . . . a state of mind during which the person affected is unable to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures so as to intelligently determine whether or not to consent to the same. . . ." § 41-41-3	"[I]n addition to such other persons as may be so authorized and empowered, any one of the following persons is authorized and empowered to consent . . . to any surgical or medical treatment or procedures. . .: [a list of relatives ensues] . . . no person so authorized and empowered may arbitrarily, obstinately or without reasonable justification withhold or refuse his consent. . . ." § 41-41-3	

				"[I]n additioin to all other remedies available at law or in equity . . . any judge . . . may . . . upon presentation of the written advice or certificate of one or more duly licensed physicians that in his or their professional opinion there is an immediate or imminent necessity for medical or surgical treatment or procedures for a minor or an adult of unsound mind, summarily consent to the . . . treatment. . . ." § 41-41-9	
MISSOURI title 22 § 431.061 et seq.	" '[T]he doctor owes a duty to his patient to make reasonable disclosure of all significant facts. . . ." Mitchell v. Robinson p.18 "[T]he patient is entitled to such information as he		"[C]onsent to surgical or medical procedures shall be implied where an emergency exists. . . ." § 431.063 [C]onsent necessary from a patient unless "mentally in-		

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
MISSOURI (cont.)	needs to make an intelligent decision and to give an informed intelligent consent" Roberson v. Menorah Medical Center p.137		competent or in a delirium. . . ." Mitchell v. Robinson p.19		
	"[E]xpert testimony is not required in order to establish whether or not a doctor has complied with his duty to communicate the advice of a treatment. . . ." Steele v. Woods p.199				
MONTANA	"[T]he sufficiency of the physician's disclosure is a matter to be measured against acceptable medical practice. Plaintiff is required to produce expert testimony to establish a standard of medical practice and show defendant's deviation from that standard." Llera v. Wisner p.810				
	"The standard of . . . conduct required with respect to disclosure of risks . . . is such disclosure as a reasonable . . . practitioner in the community would make under the same or similar cir-				

	cumstances." Negaard v. Estate of Feda p.441				
NEBRASKA §§ 44-2808, -2816, -2820	"[I]nformation which would ordinarily be provided to the patient under like circumstances . . . in a similar practice or in similar localities." § 44-2816	"[A] reasonably prudent person in the [patient's] position would not have undergone the treatment had he been properly informed and that the lack of informed consent was the proximate cause of the injury and damages claimed. . . ." § 44-2820(a)	"Failure to obtain informed consent shall include failure to obtain any express or implied consent for any operation, treatment, or procedure in a case in which a reasonably prudent health care provider in the community or similar communities would have obtained an express or implied consent. . . ." § 44-2816	i - § 44-2808	
NEVADA §§ 41A.010 to 41A.120	"[E]xplained to the patient in general terms without specific details, the procedure to be undertaken . . . alternative methods of treatment, if any, and their general nature . . . [and] that there may be risk, together with the general nature and extent of the risk involved, without enumerating such risk. . . ." § 41A.110		"[A] consent to any medical or surgical procedure will be implied if . . . in competent medical judgment the proposed medical or surgical procedure is reasonably necessary and delay in performing such procedure could reasonably be expected to result in death, disfigurement, impairment of faculties, or serious bodily harm [or] a person authorized to consent is not readily available. . . ." § 41A.120(1), (2)	i - § 41A.120(2)	"A physician . . . has conclusively obtained the consent of a patient for a medical surgical procedure if he has done the following: [made appropriate disclosure and] obtained the signature of the patient to a statement containing an explanation of the procedure, alternative methods of treatment and risks involved. . . ." § 41A.110

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
NEW HAMPSHIRE §§ 507-C:1 to 507-C:10 held unconstitutional in Carson v. Maurer)	"[A] doctor has a duty to inform his patient of the reasonable risks involved in an operation or treatment so that the patient can make an effective choice. . . . [I]ssues such as this are generally not within the competence of the average juror. . . . [W]hether a doctor uses ordinary care generally must depend on expert testimony." Folger v. Corbett pp.63-64				
NEW JERSEY	"[W]here . . . the physician failed entirely to advise plaintiff of any of the known and existing dangers associated with a proposed course of treatment, medical testimony establishing that such a failure constitutes a departure from norms of medical practice is not an essential element of a plaintiff's case. . . . Where . . . a doctor has been shown to have made disclosure of some of the risks associated with the proposed treatment, the alleged inadequacy of his disclosure must be es-		"[A] mentally competent individual has the right to make his informed choice concerning [an] operation. . . ." *In re* Quackenbush p.790	"[T]he right of choice . . . would ordinarily be based upon [a patient's] competency to assert it. . . . [T]hat . . . right . . . may be asserted on her behalf by her guardian. . . ." *In re* Quinlan p.664	

	tablished by expert medical testimony. . . ." Calabrese v. Trenton State College p.606				
NEW MEXICO	"[O]rdinarily, expert testimony is 'indispensable' to establish and make clear . . . what risks of treatment are entailed, whether alternative treatments are available, and what results should be anticipated if treatment is not rendered. Upon that medical testimony regarding disclosure, however, the determination of its observance or breach is not to be determined by the practice in the medical profession to disclose or withhold certain information, but by 'a standard set by law for physicians' based upon 'conduct which is reasonable under the circumstances.' " Henning v. Parsons pp.579-580	" '[T]here must be a causal connection between the physician's failure to adequately inform and damage to the patient. . . . Better it is . . . to resolve the causality issue on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance.' " Gerety v. Demers IV p.194	"Failure to advise the patient of . . . basic information admits of no excuse, except when an emergency requires intervention without delay." Gerety v. Demers IV p.191 "[C]onsent is ineffectual [if] plaintiff was not competent at the time he signed the consent. . . ." Demers v. Gerety I p.649 "[There are] exceptions to the general rule of disclosure, such as, 'when the patient is unconscious or otherwise incapable of consenting,' and when the patient is so ill or emotionally distraught as to foreclose a rational decision, or complicate or hinder the treatment." Gerety v. Demers IV p.194 "[T]here is 'no obligation to communicate those [hazards of treatment] of which persons of average sophistication are aware. Even more clearly, the physician bears		

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
NEW MEXICO (cont.)			no responsibility for discussion of hazards the plaintiff has already discovered****' " Henning v. Parsons p.580		
NEW YORK Pub. Health Law § 2805-d	"[Such] alternatives . . . and the reasonably foreseeable risk and benefits involved as a reasonable practitioner under similar circumstances would have disclosed in a manner permitting the patient to make a knowledgeable evaluation. . . ." § 2805-d(1)	"[A] reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis if he had been fully informed and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought. . . ." § 2805-d(3); *accord* Dries v. Gregor pp.864-65	"It shall be a defense to any action for . . . failure to obtain . . . informed consent that: (a) the risk disclosed is too commonly known to warrant disclosure; or (b) the patient assured the medical practitioner he would undergo the treatment, procedure or diagnosis regardless of the risk involved, or the patient assured the medical practitioner that he did not want to be informed of the matters to which he would be entitled to be informed; or (c) consent by or on behalf of the patient was not reasonably possible; or (d) the medical practitioner, after considering all of the attendant facts and circumstances, used rea-	"[T]he courtroom is not the proper forum nor is a legal proceeding the best method for a determination as to whether a physician should proceed to assist, cure or ameliorate a serious physical condition. . . . If there is no . . . emergency or urgency, then the Court should not, in effect, be placed in the position of making what should be a private or family determination. . . ." *In re*	

			sonable discretion as to the manner and extent to which such alternatives or risks were disclosed to the patient because he reasonably believed that the manner and extent of such disclosure could reasonably be expected to adversely and substantially affect the patient's condition." § 2805-d(4)	Nemser p.631, *but cf. In re* Storar	
NORTH CAROLINA § 90-21.13	"[T]he action of the health care provider in obtaining the consent of the patient . . . was in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities. . . ." § 90-21.13(a) (1); *accord,* Tripp v. Pate p.411	"[A] reasonable person, under all the surrounding circumstances, would have undergone such treatment or procedure. . . ." § 90-21.13(a) (3); *accord* Simons v. Georgiade	"[A doctor], except in an emergency, should make a reasonable disclosure of the risk involved. . . ." Watson v. Clutts p.621 "A valid consent is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent. . . ." § 90-21.14(c) "Any conflict between [the doctor's primary duty to do what is best for the patient] and that of a frightening disclosure ordinarily should be resolved in favor of the primary duty." Watson v. Clutts p.621	"No recovery shall be allowed against any health care provider upon the grounds that the health care treatment was rendered without the informed consent . . . of the patient's spouse, parent, guardian, nearest relative or other person authorized to give consent for the patient. . . ." § 90-21.13(a)	"A consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient or other authorized person, shall be presumed to be a valid consent. This presumption, however, may be subject to rebuttal only upon proof that such consent was obtained by fraud, deception or misrepresentation of a material fact." § 90-21.14(b)

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
NORTH DAKOTA (§ 26-41.1-01 held unconstitutional in Arneson v. Olson)	"Generally there exists as an integral part of the physician's overall obligation to his patient the duty of reasonable disclosure of the available choices with respect to the proposed therapy and of the material and known risks potentially involved in each. . . . [W]e need not reach the issue of determining if medical expert testimony is required to show a standard of disclosure among the medical profession." Winkjer v. Herr pp.587, 589 " 'The duty of a doctor to inform the patient is measured by a standard of reasonableness. The doctor must make such disclosures as appear necessary to enable a reasonable person, under the same or similar circumstances confronting the patient at the time of the disclosure to intelligently exercise his right to consent or to refuse the procedure proposed.' " Wasem v. Laskowski p.226	" 'A causal relationship exists only when disclosure of significant risks incidental to treatment would have resulted in a decision against it.' " Wasem v. Laskowski p.226	" 'A doctor . . . should not be required to discuss risks that are apparent or known to the patient, and should not be required to disclose extremely remote possibilities that at least in some instances might only serve to falsely or detrimentally alarm the particular patient.' " Wasem v. Laskowski p.226 "There is no need to disclose risks of little consequence, those that are extremely remote or those that are common knowledge as inherent in treatment." Winkjer v. Herr p.588		" 'The fact that the patient may have signed a consent form is relevant and material to the determination of whether the doctor had fulfilled his duty to disclose but is not binding upon the patient if . . . the patient did not have the information necessary to make . . . an informed consent.' " Wasem v. Laskowski p.226

OHIO § 2317.54	"[I]n general terms the nature and purpose of the procedure or procedures, and what the procedures are intended to accomplish, together with the reasonably known risks. . . ." § 2317.54(A); *accord* Siegel v. Mt. Sinai Hospital p.209	"[T]he unrevealed risk and dangers which should have been revealed . . . actually materialize and are the proximate cause of injury . . . and . . . the patient would have decided against the therapy had the material risk and dangers . . . been disclosed to him. . . ." "and whether, under the total circumstances of the patient's treatment, a reasonable prudent patient would have withheld consent had the patient been informed of all the material risk and dangers involved with the medical procedure." Siegel v. Mt. Sinai Hospital p.209	"[U]nless there exists an emergency, which prevents any delay. . . ." Lacey v. Laird p.30 "[I]f the patient for any reason including, but not limited to, competence, . . . lacks legal capacity to consent. . . ." § 2317.54(C)	"[I]f the patient . . . lacks legal capacity to consent, [consent may be given] by a person who has legal authority to consent on behalf of such patient. . . ." § 2317.54(C)	"[W]ritten consent to a surgical or medical procedure or course of procedures shall, to the extent that it fulfills all the requirements . . . of this section, be presumed to be valid and effective, in the absence of proof by a preponderance of the evidence that the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, or that the person executing the consent was not able to communicate effectively in spoken and written English or any other language in which the consent is written." § 2317.54
OKLAHOMA	"[T]he scope of a physician's communications must be measured by his patient's need to know enough to enable him to make an intelligent choice." Scott v. Bradford p.558	"[A] causal connection exists between physician's breach of the duty to disclose and patient's injury when and only when disclosure of material risks incidental to	"There is no need to disclose risks that ought to be known by everyone or already known to the patient. Further, the primary duty of a physician is to do what is best for his patient and where full disclosure would	i - Murray v. VanDevander p.304	

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
OKLAHOMA (cont.)		treatment would have resulted in a decision against it. . . . [W]e decline to jeopardize th[e] right [to know and decide] by the imposition of the 'reasonable man' standard." Scott v. Bradford pp.558-59	be detrimental to a patient's total care and best interests a physician may withhold such disclosure, . . . where there is an emergency and the patient is in no condition to determine for himself whether treatment should be administered, the privilege may be invoked. . . . The burden of proving . . . a privilege not to disclose, rest[s] upon the physician as an affirmative defense." Scott v. Bradford p.558 i - incompetency. Murray v. VanDevander p.304		
OREGON § 677.097	"In order to obtain the informed consent of a patient, a physician shall explain the following: (a) In general terms the procedure or treatment to be undertaken; (b) That there may be alternative procedures or methods of treatment, if any; and (c) That there are risks, if any, to the procedure or treatment.		"[A]n emergency demanding immediate attention in order to save the life of the patient. . . ." Hively v. Higgs p.365 "If the patient requests further explanation, the physician shall disclose . . . substantial detail . . . unless to do so would be materially detrimental to the patient. In determining that further explanation would		

	After giving th[is] explanation . . . the physician shall ask the patient if he wants a more detailed explanation. If the patient requests further explanation, the physician shall disclose in substantial detail the procedure, the viable alternatives and the material risks. . . ." § 677.097		be materially detrimental the physician shall give due consideration to the standards of practice of reasonable medical practitioners in the same or a similar community under the same or similar circumstances." § 677.097(2)			
PENNSYLVANIA title 40 § 1301.103	"[T]he physician . . . has informed the patient of the nature of the proposed procedure or treatment and of those risks and alternatives to treatment or diagnosis that a reasonable person would consider material to the decision whether or not to undergo treatment or diagnosis. . . ." § 1301.103; *accord* Cooper v. Roberts p.650	"Pennsylvania courts . . . would adopt the objective standard on the causation issue. . . ." Bowers v. Garfield p.506	"No physician . . . shall be liable for a failure to obtain an informed consent in the event of an emergency which prevents consulting the patient. . . ." § 1301.103; *accord* Malloy v. Shanahan p.804 "Where a patient is mentally and physically able to consult about his condition . . . his 'informed consent' . . . is a prerequisite to a surgical operation by his physician. . . ." Defulvio v. Holst p.1087 "No physician . . . shall be liable for failure to obtain an informed consent if . . . furnishing the information in question to the patient would have resulted in a	i - spousal permission adequate - Ciccarone v. United States p.558 i - permission must be obtained from court-appointed guardian - *In re* Yetter p.624		

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
PENNSYLVANIA (cont.)			seriously adverse effect on the patient or on the therapeutic process to the material detriment of the patient's health. . . ." § 1301.103		
RHODE ISLAND § 9-19-32	"[A] physician is bound to disclose all the known material risks peculiar to the proposed procedure. Materiality may be said to be the significance a reasonable person, in what the physician knows or should know is his patient's position, would attach to the disclosed risk or risks in deciding whether or not to submit to surgery or treatment." Wilkinson v. Vesey p.689	"[T]he plaintiff must prove that if he had been informed of the material risk, he would not have consented to the procedure and that he had been injured as a result of submitting to the procedure." Wilkinson v. Vesey p.690	"[I]n the absence of an emergency, a physician has an obligation to make a reasonable explanation and disclosure. . . ." Wilkinson v. Vesey p.686 "The keystone of this doctrine is every competent adult's right to forego treatment. . . ." Wilkinson v. Vesey p.687 "[T]he physician [is required] to disclose . . . unless the doctor makes an affirmative showing that non-disclosure was in the best interests of the patient." Wilkinson v. Vesey pp.687-688 "[T]here is no need to disclose risks that are likely to be known by the average patient or that are in fact		

			known to the patient usually because of a past experience with the procedure in question." Wilkinson v. Vesey p.689		
SOUTH CAROLINA	No Common Law or Statute				
SOUTH DAKOTA	"A doctor has the duty to make a reasonable disclosure to his patient of the significant risks in view of the patient's condition, the probabilities of success, and any alternative treatment or procedures, if such are reasonably appropriate, so that the patient has the information reasonably necessary to form the basis of an intelligent and informed consent to the proposed treatment or procedure. . . . We need not decide whether an informed consent may be proven without expert testimony. . . ." Cunningham v. Yankton Clinic pp.511-12	subjective test implicit - Cunningham v. Yankton Clinic p.512 ("The inference that had plaintiff known of the probable results of the [procedure] she would have elected [an alternative] and endured the pain is also reasonable.")	"There is a recognized exception to the rule that a physician must obtain his patient's consent both to an operation or treatment where an emergency situation exists and immediate action is necessary to preserve the patient's life or health and it is impracticable to first obtain the patient's consent which the surgeon deems to be immediately necessary. . . . However, the danger must be an immediate danger not a future one." Cunningham v. Yankton Clinic p.511		
TENNESSEE § 29-26-118	"[T]he [doctor shall] supply . . . appropriate information to the patient in obtaining his informed consent . . . in accordance with the recognized standards of acceptable professional practice in	"In a malpractice action, the claimant shall have the burden of proving . . . as a proximate result of the [doctor's] negligent act or omission,	"[E]very risk . . . no matter how remote . . . may well result in alarming a patient who is already unduly apprehensive and . . . may also actually increase the risk by reason of the psy-	spousal consent implicitly recognized in Campbell v. Oliva p.1251; Haskins v. Howard p.20	

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
TENNESSEE (cont.)	the profession and in the specialty . . . that the [doctor] practices in the community in which he practices and similar communities." § 29-26-118; construed in German v. Nichopoulos	the [patient] suffered injuries which would otherwise not have occurred." § 29-26-115(a) (3); *cf.* Longmire v. Hoey, p.310; Sawyer v. Methodist Hospital p.566	chological result of the apprehension of it. . . . [I]n discussing the elements of risk a certain amount of discretion must be employed consistent with the full disclosure necessary for an informed consent. . . ." Ball v. Mallinkrodt Chemical Works p.567; *accord* Sawyer v. Methodist Hospital p.566 "[W]henever a physician performs surgery upon a person, not being . . . protected by the exception made in cases of emergency, the physician is liable . . . for consequent injuries. . . ." Ray v. Scheibert p.71		
TEXAS title 71, art. 4590i § 6.01 to 6.07	"The Texas Medical Disclosure Panel is created to determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients. . . ." § 6.03(a)	"[T]he only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or	"[F]ailure to disclose may be found not to be negligent if there was an emergency or if for some other reason it was not medically feasible to make a disclosure. . . ." § 6.07(a) (2); *accord* Gravis v. Physicians & Surgeons Hospital p.312	"Consent of the wife for the husband's operation has no significance under Texas law unless the person is legally authorized to give such consent. . . .	"Consent to medical care that appears on the panel's list requiring disclosure shall be considered effective . . . if it is given in writing, signed by the patient or a person authorized to give the consent and by a competent witness, and if the written consent specifically

	"If medical care or surgical procedure is rendered with respect to which the panel has made no determination either way regarding a duty of disclosure, the physician or health care provider is under the duty otherwise imposed by law." § 6.02(b) "[W]hat a reasonable medical practitioner of the same school and same or similar community under the same or similar circumstances would have disclosed to his patient. . . ." Wilson v. Scott p.302	withhold consent." § 6.02 "[A] plaintiff may not recover unless he proves that he would not have consented to the treatment had he been informed of the undisclosed risk. . . ." Hartfiel v. Owen p.905	"[C]onsent will be implied when the patient is unconscious or otherwise unable to give express consent. . . ." Gravis v. Physicians & Surgeons Hospital p.311 "[S]ome disclosures may so disturb the patient that they serve as hindrances to needed treatment. . . . Certain disclosures in some instances may even be bad medical practice." Wilson v. Scott p.301	The relationship of husband and wife does not itself create such a legal authorization." Karp v. Cooley II p.421; *cf.* § 6.03(a), 6.04(a), 6.05	states the risks and hazards that are involved in the medical care or surgical procedure in the form and to the degree required [by this act]." § 6.06 "In a suit . . . based on . . . failure . . . to disclose or adequately to disclose . . . risks and hazards . . . [disclosure made in accordance with this act] . . . shall be admissible in evidence and shall create a rebuttable presumption that the requirements [of this act] have been complied with . . . and failure to disclose . . . required [by this act] shall be admissible in evidence and shall create a rebuttable presumption of a negligent failure to conform to the duty of disclosure set forth in [this act]" § 6.07(a) (1), (2); *accord* Drummond v. Hodges p.747; Goodnight v. Phillips p.200 "When a patient signs a consent form, Texas law requires that the jury be instructed that the patient is charged with reading the form even if in fact he did not." Karp v. Cooley I p.835

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
UTAH § 78-14-5	"The relationship between a doctor and his patient creates a duty in the physician to disclose to his patient any material information concerning the patient's physical condition. . . . The scope of the duty is defined by the materiality of the information in the decisional process of an ordinary individual. If a reasonable person in the position of the plaintiff would consider the information important in choosing a course of treatment then the information is material and disclosure required." Nixdorf v. Hicken p.354	"A reasonable, prudent person in the patient's position would not have consented to the health care rendered after having been fully informed as to all facts relevant to the decision to give consent." § 78-14-5(1)(f)	"[I]n the absence of an emergency or unanticipated conditions, a physician must first obtain the consent of the patient. . . ." Reiser v. Lohner p.98 "It shall be a defense to any . . . action . . . based upon failure to obtain informed consent if: (a) The risk of the serious harm to the patient from the health care provider was relatively minor; or (b) . . . was commonly known to the public; or (c) The patient stated, prior to receiving the health care . . . that he would accept the health care regardless of the risk; or that he did not want to be informed of the matters to which he would be entitled to be informed; or (d) The health care provider, after considering all the attendant facts and circumstances, used reasonable discretion as to the manner and extent to	"The following persons are authorized and empowered to consent to any health care not prohibited by law: [list of relatives follows]." § 78-14-5(4)	"It shall be a defense to any . . . action . . . based upon alleged failure to obtain informed consent if: . . . The patient or his representative executed a written consent which sets forth the nature and purpose of the intended health care and which contains a declaration that the patient accepts the risk of substantial and serious harm, if any, in hopes of obtaining desired beneficial results of health care and which acknowledges that health care providers involved have explained his condition and the proposed health care in a satisfactory manner and that all questions asked about the health care and its attendant risks have been answered in a manner satisfactory to the patient or his representative; such written consent shall be a defense to an action against a health care provider based upon failure to obtain informed consent unless the patient proves that the person giving the con-

			which risks were disclosed, if the health care provider reasonably believed that additional disclosures could be expected to have a substantial and adverse effect on the patient's condition. . . ." § 78-14-5(2)		sent lacked capacity to consent or shows by clear and convincing proof that the execution of the written consent was induced by the defendant's affirmative acts of fraudulent misrepresentation or fraudulent omission to state material facts." § 78-14-5(2) (e)
VERMONT title 12 § 1909	"[D]isclose to the patient such alternatives [to treatment or diagnosis] and the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation; or the failure to disclose . . . a reasonable answer to any specific question about foreseeable risks and benefits. . . ." § 1909(a), (d); *but see* Small v. Gifford Memorial Hospital p.706	"A reasonably prudent person in the patient's position would have undergone the treatment or diagnosis if he had been fully informed." § 1909(c) (4); *accord* Macey v. James p.804	"The right of action . . . based on a lack of informed consent shall not apply in the case of an emergency." 1909(b); *accord* Small v. Gifford Memorial Hospital p.706 "It shall be a defense to any action . . . based upon an alleged failure to obtain . . . informed consent that: (1) The risk not disclosed is too commonly known to require disclosure and that the risk is not substantial; or (2) The patient assured the medical practitioner he would undergo the treatment, procedure or diagnosis regardless of the risk involved, or the patient indicated . . . that he did not want to be informed of the matters	i - § 1909(c) (3), (d)	

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
VERMONT (cont.)			to which he would be entitled to be informed; (3) Consent by or on behalf of the patient was not reasonably possible. . . ." § 1909(c) "[A] medical practitioner shall not withhold any requested information except to the extent that a reasonable medical practitioner would withhold the information because the manner and extent of such disclosure could reasonably be expected to adversely and substantially affect the patient's condition, in which case the medical practitioner shall provide the information to a member of the immediate family, if reasonably available. . . ." § 1909(d); *cf.* Small v. Gifford Memorial Hospital p.706		
VIRGINIA	"[A] patient-plaintiff [must] show by qualified medical experts whether and to what extent information should be disclosed by the physician to his patient. . . . [T]he		"[D]isclosure would . . . pose an unreasonable threat of detriment to the patient's well-being or to his ability to make a rational decision." Bly v. Rhoads p.788		

	standard of due medical care applicable to [physicians and surgeons is] that of 'other like specialists in good standing, in the same or similar localities as defendant.' " Bly v. Rhoads pp.787, 788		"Nor must a physician communicate information which the patient already knows or of which any reasonably intelligent person should be aware." Bly v. Rhoads p.787		
WASHINGTON § 7.70.010 - 7.70.080	"The following shall be necessary elements of proof . . . of the . . . breach of the duty to secure an informed consent. . .: (a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment; (2) . . . a fact is defined as or considered to be a material fact, if a reasonably prudent person in the position of the patient . . . would attach significance to it [in] deciding whether or not to submit to the proposed treatment" § 7.70.050(1) (a) (2) *accord* Keogan v. Holy Family Hospital p.1252	"[A] reasonably prudent person under similar circumstances would not have consented to the treatment if informed of such material fact or facts. . . ." § 7.70.050(1) (c); *accord* Bertsch v. Brewer p.715	"If a recognized health care emergency exists and the patient is not legally competent to give an informed consent . . . his consent to required treatment will be implied" § 7.70.050(4); *accord* Keogan v. Holy Family Hospital p.1253 "[the patient's inability to] comprehend the nature, terms and effect of the consent given" Grannum v. Berard p.815 "[T]he patient elects not to be informed of the [statutorily required information about treatment]." § 7.70.060(2) "A physician may not be responsible for failing to disclose a risk to a patient where full disclosure would be detrimental to the pa-	"[I]n surgical cases, consent to such procedure must be obtained from either the patient, or if the patient is under some disability, from a near relative capable of giving consent. . . ." Grannum v. Berard p.814 i - § 7.70.060	"If a patient while legally competent, or his representative if he is not competent, signs a consent form which sets forth the following, the signed consent form shall constitute prima facie evidence that the patient gave his informed consent to the treatment administered and the patient has the burden of rebutting this by a preponderance of the evidence. . . . Failure to use a form shall not be admissible as evidence of failure to obtain informed consent." § 7.70.060

State	Standard of Disclosure	Standard of Causation	Defenses	Surrogate Decisionmaking	Presumption Created by Consent Form
WASHINGTON (cont.)			tient's best interests. . . ." Holt v. Nelson p.218		
WEST VIRGINIA	No Common Law or Statute				
WISCONSIN	"[T]he physician or surgeon is under the duty to provide the patient with such information as may be necessary under the circumstances then existing. . . . The right of the patient and the duty of the doctor are standards recognized and circumscribed by the law and are not entirely dependent upon the customs of a profession. . . . [T]he duty to disclose or inform cannot be summarily limited to a professional standard that may be nonexistent or inadequate to meet the informational needs of a patient." Scaria v. St. Paul Fire & Marine Ins Co. pp.652, 653	" 'A causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it. . . . [W]e believe . . . the causality issue [should be resolved] on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance.' " Scaria v. St. Paul Fire & Marine Ins Co. p.654	"A doctor should not be required to . . . discuss risks that are apparent or known to the patient. Nor should he be required to disclose extremely remote possibilities that at least in some instances might only serve to falsely or detrimentally alarm the particular patient. Likewise, a doctor's duty to inform is further limited in cases of emergency or where the patient is a child, mentally incompetent or a person is emotionally distraught or susceptible to unreasonable fears." Scaria v. St. Paul Fire & Marine Ins Co p.653		
WYOMING	"[U]nder certain circumstances a physician has a duty to reveal any serious				

	risks which are involved in a contemplated operation. But, how a physician chooses to discharge his obligations to a patient involves primarily a question of medical judgment. As long as his disclosure is sufficient to assure an informed consent, and if it appears that he proceeded as competent medical men would have done in a similar situation, the physician's actions should not be called into question." Govin v. Hunter p.423				

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    Roberts v. Wood, 206 F. Supp. 579 (D. Ala. 1962)

ALASKA - § 09.55.556
    Patrick v. Sedwick, 391 P.2d 453 (1964)
    Poulin v. Zartman, 542 P.2d 251 (1975)

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    Shetter v. Rochelle, 2 Ariz. App. 358, 409 P.2d 74 (1965)
    Riedisser v. Nelson, 111 Ariz 542, 534 P.2d 1052 (1975)
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    Hales v. Pittman, 118 Ariz. 305, 576 P.2d 493 (1978)
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    Pegram v. Sisco, 406 F. Supp 776 (W.D. Ark.), aff'd 547 F.2d 1172 (1976)

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    Haven v. Randolph, 494 F.2d 1069 (D.C. Cir. 1972)
    Henderson v. Milobsky, 595 F.2d 654 (D.C. Cir. 1978)

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    Russell v. Harwick, 166 So.2d 904 (1964)

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Thomas v. Berrios, 348 So.2d 905 (Ct. App. 1977)
Meretsky v. Ellenby, 370 So.2d 1222 (Ct. App. 1979)

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Mull v. Emory University, Inc. 114 Ga. App. 63, 150 S.E.2d 276 (1966)
Young v. Yarn, 136 Ga. App. 737, 222 S.E.2d 113 (1975)
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- In re Dinnerstein, 6 Mass. App. 466, 380 N.E.2d 134 (1978)
- Custody of a Minor, 385 Mass. 697, 434 N.E.2d 601 (1982)
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